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
Direction de l'amélioration de la performance et de la conformité

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347 Preston St, 4th Floor
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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Nov 25, 2014	2014_199161_0026	O-001113-14	Critical Incident System

Licensee/Titulaire de permis

THE OTTAWA JEWISH HOME FOR THE AGED
10 Nadolny Sachs Private, Ottawa-Carleton, ON, K2A-4G7

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

HILLEL LODGE
10 NADOLNY SACHS PRIVATE, OTTAWA, ON, K2A-4G7

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

KATHLEEN SMID (161)

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): October 24, 27, 28, 29, 30, 31, 2014 on-site.

During the course of the inspection, the inspector(s) spoke with the Executive Director, Director of Care, Director of Social Work, Programs and Support Service/Admissions, Director of Environmental Services, RAI Coordinator, a Personal Support Worker and two representatives from Arjo Huntleigh Canada Inc.

During the course of the inspection, the inspector(s) reviewed MOHLTC Home Emergency Pager information on an identified date in the Fall of 2014, an identified MOHLTC Critical Incident Report, the identified Resident's health record, home's Incident/Risk Management Investigation notes on an identified date in the Fall of 2014, home's Policy and Procedures (1) reference code Nursing 2011/MLSSP titled "Mechanical Lifting and Sling Safety Protocol" dated 05/12/2011, and (2) reference code Environmental Services 2014/Laundry/GLLS titled "Guidelines: Laundering Lift Slings - Commercial Machines", ArjoHuntLeigh documents: Passive Clip Slings dated November 2011, Arjo Slings Issue 4, Maxi Move Instructions for Use dated February 2013, Arjo Slings User Guide dated March 2005 and select email correspondence.

The following Inspection Protocols were used during this inspection:
Safe and Secure Home

Findings of Non-Compliance were found during this inspection.

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	Legendé 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 :

The licensee failed to comply with the O. Reg 79/10 s. 36, in that on an identified date in the Fall of 2014 Resident #001 was not transferred from his/her chair to his/her bed safely.

On an identified date in the Fall of 2014 the Director was notified by telephone, by the home's Director of Care via the LTC Home Emergency pager, that earlier in the day, two staff members were transferring Resident #001 using a mechanical lift. The

Resident slipped through the mechanical lift sling and fell on the floor, sustaining a fractured right hip and a head injury. The Director of Care of the home indicated that she believed that the two Personal Support Workers were not using the appropriate type nor size of a mechanical lift sling at the time of this incident.

Resident #001's most recent plan of care was reviewed. In the Activities of Daily Living section of the care plan, it specifies that Resident #001 is to be transferred using a mechanical lift with a "large sized standard sling." A review of the home's computerized software program, Pointclickcare, indicated that this direction had not changed since April 2013. This was verified by the RAI Coordinator.

On an identified date in the Fall of 2014, PSW #S105 was interviewed by Inspector #161 regarding Resident #001's transfer on an earlier identified date in the Fall of 2014 from the chair to his/her bed. PSW #105 indicated to both Inspector #161 and Ms Abrams, the Director of Social Work, Programs and Support Service/Admissions that on an identified date in the Fall of 2014, Resident #001 was sitting in his/her chair and requested PSW #S105 and the attending agency PSW to transfer his/her back to bed. PSW #S105 looked for the Resident's "large sized standard sling" in the Resident's room and could not find it. PSW #S105 telephoned the laundry room looking for the Resident #001's sling and was told that the Resident's sling had been washed and was currently hanging up to dry. PSW #S105 was unable to find a "large sized standard lift sling" on the homes first, second and third floors. PSW #105 subsequently placed Resident #001 in an "extra-large toileting sling" and attempted to transfer the Resident from his/her chair to his/her bed using a mechanical lift. As PSW #S105 was operating the positioning handle on the mechanical lift to raise Resident #001 into a sitting position, the Resident suddenly fell out of the opening located at the bottom of the "extra-large toileting sling" onto the floor. Resident #001 sustained a fractured left hip and a head injury. Resident #001 was transferred immediately to the hospital where his/her medical condition deteriorated, resulting in the Resident's death the following day.

At the request of Inspector #161, PSW #S105 proceeded to demonstrate how she placed the "extra-large toileting sling" around Resident #001 and used the mechanical lift to transfer Resident #001. Using Ms Abrams, the Director of Social Work, Programs and Support Service/Admissions as a substitute for the Resident, PSW #S105 placed the "extra-large toileting sling" around Ms. Abrams and positioned both of Ms. Abram's arms inside the sling. As PSW #S105 was operating the positional handle on the mechanical lift to sit Ms Abrams upright, she began to slip out of the

opening located at the bottom of the "extra-large toileting sling." As a result of this demonstration, it was observed that PSW #S105 incorrectly applied the toileting sling to Ms Abrams in that Ms Abrams arms were placed inside the toileting sling rather than outside the sling as per manufacturer's instructions. During discussion with PSW #S105, she indicated to both Inspector #161 and Ms Abrams that she did not receive training regarding the difference in usage between "standard slings" and "toileting slings." She stated "I thought I could use the sling for toileting and transferring. I didn't know it was just for toileting."

As such, on October 7, 2014, Resident #001 was not safely transferred from bed to chair due to PSW #S105 placing the Resident in an (a) incorrect type and (b) size of mechanical sling that she subsequently (c) applied incorrectly and then attempted to transfer Resident #001 with a mechanical lift which resulted in the Resident falling to the floor and sustaining a fractured left hip and a head injury. Resident #001 was transferred immediately to the hospital where his/her medical condition deteriorated, resulting in the Resident's death the following day. [s. 36.]

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 O.Reg 79/10, s. 44. Every licensee of a long-term care home shall ensure that supplies, equipment and devices are readily available at the home to meet the nursing and personal care needs of residents. O. Reg. 79/10, s. 44.

Findings/Faits saillants :

The licensee failed to ensure that equipment, specifically a "large sized standard sling" model #MAA2000 used with a mechanical lift, was readily available at the home to meet the nursing and personal care needs of Resident # 001.

According to the home's computerized Pointclickcare software program, since April 2013, Resident #001 was transferred with a mechanical lift while seated in a "large sized standard sling." This was verified by the RAI Coordinator. The Director of Care indicated that this specific sling is model #MAA2000.

On a specified date in the Fall of 2014 Resident #001 was sitting in his/her chair and requested PSW #S105 to transfer him/her back to bed. PSW #S105 looked for the Resident's "large sized standard sling" in the Resident's room and could not find it. PSW #S105 telephoned the laundry room looking for the Resident #001's sling and was told that the Resident's sling had been washed and was currently hanging up to dry. PSW #S105 was unable to find a "large sized standard lift sling" on the homes first, second and third floors. PSW #105 subsequently placed Resident #001 in an "extra-large toileting sling" and attempted to transfer the Resident from the chair to his/her bed using a mechanical lift. As PSW #S105 was operating the positioning handle on the mechanical lift to raise Resident #001 into a sitting position, the Resident suddenly fell out of the opening located at the bottom of the "extra-large toileting sling" onto the floor. Resident #001 sustained a fractured left hip and a head injury. Resident #001 was transferred immediately to the hospital where his/her medical condition deteriorated, resulting in the Resident's death the following day.

The lack of a readily available "large sized standard sling" model #MAA2000 was verified by the Director of Care and the Director of Environmental Services and Coordinator of Quality. [s. 44.]

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 are an adequate supply of all types and sizes of mechanical lift slings used in the home and that they are readily available at all times to staff, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 219. Retraining

Specifically failed to comply with the following:

s. 219. (1) The intervals for the purposes of subsection 76 (4) of the Act are annual intervals. O. Reg. 79/10, s. 219 (1).

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 79/10, s. 219 (1) in that the licensee has failed to ensure that mandatory retraining has been provided annually, specifically in 2013.

As per LTCHA, 2007, c. 8, s. 76 (4) and O.Reg 79/10, s. 218(2), all nursing staff shall receive annual training regarding the safe and correct use of mechanical lifts. Retraining is to occur as prescribed.

On October 28, 2014 Inspector #161 asked the Director of Environmental Services and Coordinator of Quality, for the 2013 nursing staff attendance records of the mandatory training regarding the safe and correct use of mechanical lifts. A review of these 2013 attendance records indicated that 18/86 (20.9%) of nursing staff did not receive the mandatory training regarding the safe and correct use of mechanical lifts. This was verified by the Director of Care and the Director of Environmental Services and Coordinator of Quality. [s. 219. (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 all nursing staff shall receive annual training regarding the safe and correct use of mechanical lifts and their respective slings, to be implemented voluntarily.

Issued on this 26th day of November, 2014

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

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) :	KATHLEEN SMID (161)
Inspection No. / No de l'inspection :	2014_199161_0026
Log No. / Registre no:	O-001113-14
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Nov 25, 2014
Licensee / Titulaire de permis :	THE OTTAWA JEWISH HOME FOR THE AGED 10 Nadolny Sachs Private, Ottawa-Carleton, ON, K2A-4G7
LTC Home / Foyer de SLD :	HILLEL LODGE 10 NADOLNY SACHS PRIVATE, OTTAWA, ON, K2A-4G7
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	STEPHEN SCHNEIDERMAN

To THE OTTAWA JEWISH HOME FOR THE AGED, 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. 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 will ensure that all staff who are involved in transferring Residents use safe transferring equipment and techniques when assisting Residents as detailed below:

All Residents currently requiring a mechanical lift will be re-assessed for the correct type of mechanical lift to be used, and the type and size of sling to be used. This information will be recorded in the Resident's plan of care.

All staff who are involved in transferring Residents with a mechanical lift will receive documented re-education which will include, but is not limited to the following components:

1. The types of mechanical lifts used in the home and their criteria for use,
2. The types of slings used with mechanical lifts in the home and their criteria for use,
3. Instructions for measuring a Resident for a correctly fitting sling,
4. Complete return demonstration for their ability to ensure the measurement of a correctly fitting sling and the application of same,
5. Complete return demonstration for their ability to safely transfer a Resident as a lift operator on any/all different styles of transfer slings that they may be required to use in the course of their duties, and,
6. The process by which to obtain an identical replacement sling when required.

Grounds / Motifs :

1. The licensee failed to comply with the O. Reg 79/10 s. 36, in that on an identified date in the Fall of 2014 Resident #001 was not transferred from his/her chair to his/her bed safely.

On an identified date in the Fall of 2014 the Director was notified by telephone, by the home's Director of Care via the LTC Home Emergency pager, that earlier in the day, two staff members were transferring Resident #001 using a mechanical lift. The Resident slipped through the mechanical lift sling and fell on the floor, sustaining a fractured right hip and a head injury. The Director of Care of the home indicated that she believed that the two Personal Support Workers were not using the appropriate type nor size of a mechanical lift sling at the time of this incident.

Resident #001's most recent plan of care was reviewed. In the Activities of Daily Living section of the care plan, it specifies that Resident #001 is to be transferred using a mechanical lift with a "large sized standard sling." A review of the home's computerized software program, Pointclickcare, indicated that this direction had not changed since April 2013. This was verified by the RAI Coordinator.

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At the request of Inspector #161, PSW #S105 proceeded to demonstrate how

she placed the "extra-large toileting sling" around Resident #001 and used the mechanical lift to transfer Resident #001. Using Ms Abrams, the Director of Social Work, Programs and Support Service/Admissions as a substitute for the Resident, PSW #S105 placed the "extra-large toileting sling" around Ms. Abrams and positioned both of Ms. Abram's arms inside the sling. As PSW #S105 was operating the positional handle on the mechanical lift to sit Ms Abrams upright, she began to slip out of the opening located at the bottom of the "extra-large toileting sling." As a result of this demonstration, it was observed that PSW #S105 incorrectly applied the toileting sling to Ms Abrams in that Ms Abrams arms were placed inside the toileting sling rather than outside the sling as per manufacturer's instructions. During discussion with PSW #S105, she indicated to both Inspector #161 and Ms Abrams that she did not receive training regarding the difference in usage between "standard slings" and "toileting slings." She stated "I thought I could use the sling for toileting and transferring. I didn't know it was just for toileting."

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(161)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 28, 2015

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 25th day of November, 2014

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : KATHLEEN SMID

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