Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch
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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Nov 20, 21, 2012	2012_031194_0057	Critical Incident

Licensee/Titulaire de permis

REGIONAL MUNICIPALITY OF DURHAM
605 Rossland Road East, WHITBY, ON, L1N-6A3

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

HILLSDALE ESTATES
590 Oshawa Blvd. North, OSHAWA, ON, L1G-5T9

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

CHANTAL LAFRENIERE (194)

Inspection Summary/Résumé de l'inspection

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

During the course of the inspection, the inspector(s) spoke with Director of Care(DOC), Administrative Assistant, Resident Care Co ordinator(RCC) and RAI Co ordinator

During the course of the inspection, the inspector(s) review of two resident's clinical health records, licensee's investigation report for resident #001, licensee's policy on "Lift and Transfer Policy" and "Fall Prevention and Management Program", educational records for identified staff member and Two Critical Incident Reports

Two Critical Incident inspections were completed in this report; Log# O-002768-11 and Log #O-002791-11

The following Inspection Protocols were used during this inspection:
Falls Prevention

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

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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. 8. Policies, etc., to be followed, and records
Specifically failed to comply with the following subsections:

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
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee failed to comply with O.Reg 79/10 s.8(1)(b) when it's "Lift and Transfer Policy" # ADM-04-08-05, was not complied with.

In accordance with the requirements of O.Reg. 79/10 s.30(1)1 the licensee shall ensure that the following is complied with in respect of each of the organized programs required under section 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation: There must be a written description of the program that includes its goals and objective and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes.

The licensee's "Lift and Transfer Policy # ADM-04-08-05" directs that;

Approved techniques for lifting, transferring and repositioning of residents with use of proper body mechanics are reviewed and demonstrated during each general orientation and during annual mandatory in-services.

Tub Chair Lift:
Two or more trained personnel must be participating during the transfer.
Ensure resident is position comfortably and apply safety belt.

The licensee's educational training records confirms that Staff # S100 received training for "Resident Safety-mechanical lifts" in 2010. There is no evidence of further training related to lifts and transfers noted on the staff's educational file for 2011 or 2012.

The Licensee's investigation report confirms that staff #S100 did not apply the seat belt, or ensure that two staff members where present during a transfer with the Tub Chair Lift, which resulted in a fall with injury.[s.8(1)(b)]Log # 002768-11

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

Findings/Faits saillants :

1. The licensee failed to comply with O.Reg 79/10 s. 36 when the staff did not ensure that safe transferring and positioning devices or techniques were used when assisting resident #001, using a mechanical lift.

The plan of care for resident #001 directs that resident uses Argo Tub bath X 2 weekly.

Licensee's "Lift and transfer Policy" ADM-04-08-05 dated August 2011 directs that;

Tub Chair Lift:
Two or more trained personnel must be participating during the transfer.
Ensure resident is position comfortably and apply safety belt.

Resident #001 was bathed using a mechanical lift (Tub Chair Lift). Resident #001 stated only one staff member was present during the bath. Staff member stated no assistance was received from her co-workers while using the mechanical lift. Staff member also stated that the safety belt was not applied during transfer. The resident sustained an injury post fall.[s.36]Log #002768-11

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents
Specifically failed to comply with the following subsections:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition.
2. An environmental hazard, including a breakdown or failure of the security system or a breakdown of major equipment or a system in the home that affects the provision of care or the safety, security or well-being of residents for a period greater than six hours.
3. A missing or unaccounted for controlled substance.
4. An injury in respect of which a person is taken to hospital.
5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The Licensee failed to comply with O.Reg 79/10 s.107(3)4 when the Director was not informed following an injury in respect of which a person is taken to hospital, no later than one business day after the occurrence of the incident.

Resident #001 was sent to hospital post fall with an injury. The Licensee notified the Director 3 days after the incident. [s.107(3)]Log #002768-11

Issued on this 21st day of November, 2012

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs
Chantal Lafrenière (194)