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 prévue le Loi de 2007 les foyers de soins de longue

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch
Division de la responsabilisation et de la performance du système de santé
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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
Feb 13, 14, 15, 22, 2012	2012_109153_0005	Critical Incident

Licensee/Titulaire de permis

2063412 ONTARIO LIMITED AS GENERAL PARTNER OF 2063412 INVESTMENT LP
302 Town Centre Blvd., Suite #200, MARKHAM, ON, L3R-0E8

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

LEISUREWORLD CAREGIVING CENTRE - CREEDAN VALLEY
143 MARY STREET, CREEMORE, ON, L0M-1G0

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

LYNN PARSONS (153)

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,Program Manager,Environmental Supervisor, Registered Nurse and Personal Support Workers

During the course of the inspection, the inspector(s) Reviewed the following records: clinical health records, preventative maintenance report for load testing of ceiling lift, minimal lift policy and Liko Universal Sling Instruction Guide.
Completed observations involving transfer of residents.

The following Inspection Protocols were used during this inspection:

Personal Support Services

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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. 86. Infection prevention and control program

Specifically failed to comply with the following subsections:

s. 86. (2) The infection prevention and control program must include,
(a) daily monitoring to detect the presence of infection in residents of the long-term care home; and
(b) measures to prevent the transmission of infections. 2007, c. 8, s. 86. (2).

Findings/Faits saillants :

1. On February 13, 2012 the following infection control issues were observed:@ 13:00 hrs.
Resident #1 in Room A was transferred from chair to bed with an unlabeled medium sized sling. After the transfer was completed the staff checked the sling for soiled areas and returned it to the linen closet for staff to use with other residents.
2.Resident #2 in Room A was transferred from chair to bed using an unlabeled small sling. After the transfer was completed staff placed the same sling on top of the soiled incontinent brief bin in the hallway outside Room B. Staff proceeded to enter Room B and transfer Resident #3 from chair to bed using the unlabeled small sling that had been placed on top of the soiled incontinent brief hamper.
3. Observed personal support worker exit Room A with a soiled incontinent brief and discard the brief in the soiled hamper and then proceed to enter a resident room further up the hallway to answer a call bell without completing appropriate hand hygiene measures.

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 implement a process to ensure lift slings are not shared among residents to prevent the transmission of infections, to be implemented voluntarily.

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.Resident #1's plan of care directs staff to transfer with a mechanical lift using 2 persons.
2.Resident #1 fell from the lift sling on February 16, 2011 while being transferred from bed to chair with 1 staff member. The staff member used an extra large sling for the transfer when the resident had been assessed to require a medium sling for all transfers.
3.The home's Minimal Lift policy states, " at least 2 caregivers shall be present from the beginning to the end of the lift/transfer/repositioning of a resident when using a mechanical lift".
4.Resident required transfer to hospital for assessment to rule out serious injury. Resident # 1 experienced a hematoma to occipital region and abrasion of skin on left flank.
5.Through interviews with staff it was confirmed that Resident #1 was transferred by one staff member using the wrong sized sling.

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 transfer and positioning devices as assessed and in accordance to Home policy, to be implemented voluntarily.

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 subsections:

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. Resident #1 sustained injuries during transfer when a staff member transferred the resident alone with the wrong size transfer sling.
The plan of care for Resident #1 indicates "2 person physical assist with a mechanical lift".
On February 16, 2011, a personal support worker transferred the resident from bed to chair using the wrong size sling and without the second person.
The home's minimal lift policy VII 060 states, "at least 2 caregivers shall be present from the beginning to the end of the lift/transfer/repositioning of a resident when using a mechanical lift."
Through interviews and record reviews it was confirmed that a personal support worker transferred the resident with the wrong size sling without the assistance of another staff member.

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 all staff follow direction regarding transfers as outlined in the plan of care and according to home policy, to be implemented voluntarily.

Issued on this 5th day of March, 2012

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