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 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
Nov 3, 4, 14, 21, 2011; Jan 19, Mar 8, 20, 21, 2012	2011_060127_0042	Critical Incident

Licensee/Titulaire de permis

THE REGIONAL MUNICIPALITY OF PEEL
10 PEEL CENTRE DRIVE, BRAMPTON, ON, L6T-4B9

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

PEEL MANOR
525 MAIN STREET NORTH, BRAMPTON, ON, L6X-1N9

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

RICHARD HAYDEN (127)

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 the administrator, director of care, one supervisor of care and one resident regarding H-001476-11 and H-002145-11.

During the course of the inspection, the inspector(s) reviewed management's documentation related to the incident; a resident's plan of care; an employee's training record; the Minimal Lift Program and the associated policy and procedure.

The following Inspection Protocols were used during this inspection:

Critical Incident Response

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

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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. 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. The licensee failed to ensure the care set out in the plan of care is provided to the resident as specified in the plan. On November 3, 2011, the inspector confirmed the following: an identified resident suffered a fall in 2011 after being transferred via a lift by one personal support worker (PSW). Prior to the incident, the resident's plan of care indicated he/she was a two-person transfer for all lifts. The resident received injuries as a result of the fall.

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. On November 3, 2011, the inspector confirmed the following: An identified resident suffered a fall in 2011, after being transferred via a lift by one personal support worker (PSW). Prior to the incident, the resident's plan of care indicated he/she was a two-person transfer for all lifts. The PSW received training on use of lifts as part of his/her orientation and subsequently attended the following training or re-training between 2006 and 2010: Minimal Lift; New Slings; H&S Lift Signing Protocol; Proper Transfer/Lifts; Lifts and Transfers; Care of a Bariatric Client; Lifts/Stands; Rehab - Transfer Technique; and Ceiling Lift.

The inspector spoke with the resident and he/she was able to describe the fall incident in detail and was adamant that the PSW was alone and did not request assistance from a co-worker to transfer him/her.

On November 4, 2011, the inspector reviewed the Region of Peel Long Term Care Centres' Minimal Lift Program (revised March 2011). It stated on page 18, "It is mandatory that two staffs are present when using the mechanical lift, one to operate the lift and the other to guide the resident in the sling." On page 21 under the heading Ceiling Lifts, it stated, "2. The ceiling lift must be operated by 2 trained staff at all times."

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 with ensuring staff use safe transferring techniques for every resident transfer, to be implemented voluntarily.

Issued on this 22nd day of March, 2012

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