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

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 apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Apr 5, 2017	2017_618211_0006	006058-17	Critical Incident System

Licensee/Titulaire de permis

BRUYERE CONTINUING CARE INC.
43 BRUYERE STREET OTTAWA ON K1N 5C8

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

RESIDENCE SAINT- LOUIS
879 CHEMIN PARC HIAWATHA OTTAWA ON K1C 2Z6

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

JOELLE TAILLEFER (211)

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): April 3, 4, 2017

During the course of the inspection, the inspector(s) spoke with the Director of Long Term Care, the Administrator/Clinical Manager, the Facility Manager, the Nurse Practitioner (NP), the Long Term Care Educator, several Registered Nurses (R.N.), several Registered Practical Nurses (R.P.N.), several Personal Support Workers (PSW), and the Administrative Assistant.

In addition, the inspector conducted a tour of the resident care areas, reviewed residents' health care records, staff work routines, observed resident tub rooms, resident common areas, the delivery of resident care and services and staff to resident and resident to resident interactions.

The following Inspection Protocols were used during this inspection:
Hospitalization and Change in Condition
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	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 :

1. The licensee has failed to ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

The Critical Incident Report was sent by the home on an identified date, relating to an incident that caused an injury to resident #001 for which the resident was taken to the

hospital and resulted in a significant change in resident's health status. The CIS report indicated that resident #001 hit a body area, ultimately causing a severe injury. The resident also sustained an injury to another specified body area.

Resident #001 was admitted in the home on an identified date and passed away on a specified date. The diagnoses include multiple medical health issues.

Review of the resident's progress notes on an identified date, indicated RPN #108 was informed by PSW #104 that the resident's area sustained an altered skin integrity because the resident hit the metal support piece on the tub room's bed equipment.

The progress notes on an identified date, indicated that the Nurse Practitioner (NP) was contacted and assessed the resident. The NP observed that the resident sustained a specified trauma and described the injury has an altered skin integrity to the identified resident`s body area. The resident was transferred to the hospital by the paramedics.

The progress notes on an identified date, indicated that a family member of the resident informed the home that intervention were applied to the resident's altered skin integrity and that they were informed that the resident sustained an injury to another body area. The next day, the notes indicate that the family contacted the home to inform that the resident was under specialized care in the hospital. Three days later, the resident died in the hospital.

The progress notes from the physician on an identified date, indicated that he witnessed in the past during his assessment that resident #001 was experiencing specific movements in the wheelchair and the identified body area would thrash posteriorly as described by the aides. The physician wrote that he spoke with the health care aide and understood that in the past, the resident would at times go into two identified movements during the bathing. Also, he wrote that he understood that the resident suffered from an identified medical problem from the injury.

Review of the home's investigation on two identified dates, indicated that PSW #104 reported that the resident was transferred in and out from the tub bath with the assistance of two staff. PSW #104 indicated that the resident was transferred from the tub bath to the bed placed within the tub room using the ceiling lift. PSW #104 stated that the bed was placed in a way that when the resident was transferred with the ceiling lift, the transfer only allowed to have the resident #001's identified body area positioned in a certain way in the bed. PSW #104 revealed that when she was drying the resident on the

bed, the resident had a sudden identified movement and hit the identified body area on the metal support of the bed equipment. The notes also indicated that PSW #104 indicated that she did not know how the resident could have sustained the other injury of the other body area.

The resident's written plan of care on a specified date, indicated to review lift and transfer techniques and to ensure that there is the appropriate pictogram at the head of the bed. The care sheet indicated that the resident required two person assistance for the mechanical lift.

Interviews with PSW #104, PSW #105, RN #103 on April 3, 2017 and interview with RPN #108 on April 4, 2017, indicated that the resident was a total assistance and required two staff assistance by using the mechanical lift during all transfer and they were not aware of any incident of fall for resident #001.

Interview with the PSW #104 on April 3, 2017, indicated that the incident happened on an identified floor situated on an identified Unit in the tub room. PSW #104 demonstrated to Inspector #211 that the tub room has a tub bath, a bed and a ceiling lift. PSW #104 indicated that resident #001 hit the identified body area on one of the metal support of the bed equipment. Inspector #211 observed that the bed had two metal support brackets in the inside of one part of the bed. However, there were no such brackets on the other part of the bed.

Interview with the Facility Manager on April 4, 2017, stated that the bed found in the tub room was mounted as indicated in the "Bertec Medical Manufacture Instruction" and the two metal support brackets are to be positioned in the inside of the bed's area.

Interview with PSW #104 on April 3, 2017, stated resident #001 was transferred in the tub bath using the ceiling lift with the assistance of PSW #113. During the transfer into the tub bath, the resident did not hit a body area. The resident skin was intact. PSW #104 stated that she bathed the resident alone. When the resident's bath was completed, she transferred the resident from the tub bath to the bed using the ceiling lift with the assistance of PSW #105. During the transfer, the resident did not hit a body area on the bed. The resident was placed lying down flat on his/her back. PSW #104 stated that the bed was placed in a way that when the resident was transferred with the ceiling lift, the transfer only allowed to have the resident #001's identified body area positioned in a specific area of the bed. PSW #104 indicated that PSW #105 left the room when she started drying the resident's front body with a towel. The resident's identified body area

was placed on a plastic pillow close to the identified bed area. Suddenly, the resident's identified body area made a specific movement and hit the identified body area very hard on the piece of metal. PSW #104 stated she saw an altered skin integrity behind the resident's body area and immediately pulled the call bell in the tub room and then informed RPN #108.

Interview with PSW #113 on April 4, 2017, stated that she assist PSW #104 to transfer resident #001 using ceiling lift into the tub bath. The resident's skin was intact and the transfer went well without an incident.

Interview with PSW #105 on April 3, 2017, stated she assisted PSW #104 to transfer resident #001 from the tub bath to the bed using the ceiling lift. PSW #105 indicated that she observed that the resident's identified body area was at the identified part of the bed. PSW #105 specified that the bed was always placed in a way that when a resident was transferred from the tub bath to the bed, the resident's identified body area was directed to the identified part of the bed.

Interview with RN #103 on April 3, 2017, stated at the time of the incident that the bed in the tub room was positioned on the wrong side and consequently resident #001's identified body area was placed toward the identified part of the bed. RN #103 indicated that she was not aware how the resident could have sustained an injury to the other identified body area.

Interview with RPN #108 on April 4, 2017, stated that when she entered the tub room, the resident was lying flat on his/her back and the body was still doing specified movements. She observed a altered skin integrity in the back of resident #001's identified body area. The resident was transferred in the wheelchair and brought in the identify room. The resident was assessed immediately by the NP.

Interviews with PSW #104, PSW #109, PSW #110 and RPN #107 on April 3, 2017, indicated that resident #001 was not complaining of pain during transfer or repositioning.

Interview with the Administrator on April 4, 2017, indicated that during her investigation she asked PSW #104 the reason why the resident's specified body area was put at the identified part of the bed and not in the different direction. The Administrator indicated that she was explained by PSW #104 that the way the ceiling lift was installed, the resident's identified body area was going to the identified part of the bed during the

transfer. The Administrator stated when she asked the PSW #104 why the bed was not turn in a way that the resident was going to the other direction, the PSW replied that she thought she was not allowed to change the direction of the bed. The Administrator stated that the cause of the other injury was unknown.

The licensee has failed to ensure that resident #001's transfer and positioning was safe as the resident's identified body area was positioned by the identified part of the bed, thus causing the resident injury to the identify body area. [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 that staff use safe transferring and positioning techniques when assisting residents using the ceiling lift in the tub rooms, to be implemented voluntarily.

Issued on this 6th day of April, 2017

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

Original report signed by the inspector.