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

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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
Nov 20, 2015	2015_417178_0017	026809-15	Critical Incident System

Licensee/Titulaire de permis

CORPORATION OF THE COUNTY OF SIMCOE
1110 Highway 26 Midhurst ON L0L 1X0

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

SUNSET MANOR HOME FOR SENIOR CITIZENS
49 RAGLAN STREET COLLINGWOOD ON L9Y 4X1

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

SUSAN LUI (178)

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 15, 16, 26, November 17, 2015.

During the course of the inspection, the inspector(s) spoke with the Administrator, the acting Director of Care (DOC), the Quality and Development Coordinator, registered nursing staff, Sunset Manor personal support workers (PSWs), nursing agency PSWs, the coroner, family of a resident.

During the inspection, the inspector also reviewed resident records and home records, and observed lift equipment.

The following Inspection Protocols were used during this inspection:
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 techniques when assisting residents.

Review of an identified Critical Incident System report, Resident #01's progress notes, and the home's investigation notes, confirm the following facts:
-on an identified date, Resident #01 was being transferred from bed to wheelchair by two personal support workers (PSWs) working under contract from an identified nursing care agency. The two PSWs were using a mechanical hoyer lift to transfer the resident from bed to wheelchair.
-the straps of the lift sling were not correctly connected to the mechanical lift, which resulted in the resident slipping out of the lift sling during the transfer procedure.
-as a result, the resident fell to the floor from a height of approximately three feet.
-the resident was assessed after the incident, and did not appear to be injured.
-two days later, the resident began to experience pain with movement. The resident was X-rayed and it was determined that he/she had sustained a fracture.
-the decision was made not to treat the fracture surgically, but rather to provide comfort measures.
-the resident later passed away.

During interview, nursing agency PSW #101 confirmed that he/she had failed to properly secure the lift sling straps to the lift and that this caused the resident to slide out of the lift sling and onto the floor.

Nursing agency PSWs #101 and #102 confirmed that they had received orientation regarding how to use this type of lift, and review of the PSWs' orientation checklists support this fact. Both PSWs confirmed that prior to the incident they had, along with home staff, each used the same type of lift to safely transfer other residents in the home.

Interview with the home's Administrator confirmed that since the incident the home has revised their Minimal Lift Procedures policy to include the fact that during manual and mechanical lift transfers, one County of Simcoe Long Term Care Nursing staff must always be present and assist if Agency staff and/or students are working.

Review of the home's Minimal Lifts Procedures Policy number NPC-G-95, effective October 2015, and the Common Orientation Checklist, Policy number NPC C-05-05, effective September 2015, confirmed that both documents include the above mentioned revision. [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, to be implemented voluntarily.

Issued on this 3rd day of December, 2015

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

Original report signed by the inspector.