Ontario

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

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

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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☐ Licensee Copy/Copie du Titulaire ☒ Public Copy/Copie Public

Date(s) of inspection/Date de l'inspection	Inspection No/ d'inspection	Type of Inspection/Genre d'inspection
May 11, 12 - 2011	2011_133_2675_11May142546	Critical Incident Log O-001913

Licensee/Titulaire

Valley Manor Inc.
88 Mintha Street
P.O. Box 880
Barry's Bay, Ontario
K0J 1B0

Fax: 613-756-7601

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

Valley Manor Nursing Home
88 Mintha Street
P.O. Box 880
Barry's Bay, Ontario
K0J 1B0

Fax: 613-756-7601

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

Jessica Lapensée, #133

Inspection Summary/Sommaire d'inspection

The purpose of this inspection was to conduct a critical incident (#2675-000014-10) inspection related to a resident who fell from a ceiling lift while being transferred from their wheelchair to their bed.

During the course of the inspection, the inspector spoke with the administrator, the director of care, the plant engineer, the adjuvant, the dietary/housekeeping/laundry supervisor, laundry services staff, housekeeping services staff and personal support workers.

During the course of the inspection, the inspector conducted a walk-through of all resident home areas and common areas, observed all ceiling lifts in resident's bedrooms, reviewed maintenance services documentation related to ceiling lifts and reviewed all documentation amassed by the administrator related to her investigation into the critical incident.

The following Inspection Protocols were used in part or in whole during this inspection:
Accommodation Services – Maintenance
Training and Orientation

Findings of Non-Compliance were found during this inspection. The following action was taken:

1 WN
1 CO: CO # 001

NON- COMPLIANCE / (Non-respectés)

Definitions/Définitions

WN – Written Notifications/Avis écrit
VPC – Voluntary Plan of Correction/Plan de redressement volontaire
DR – Director Referral/Régisseur envoyé
CO – Compliance Order/Ordres de conformité
WAO – Work and Activity Order/Ordres: travaux et activités

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA. 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.)	Le suivant constituer un avis d'écrit de l'exigence prévue le paragraphe 1 de section 152 de les foyers de soins de longue durée. Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue durée* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prévue par la présente loi" au paragraphe 2(1) de la loi.

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.

Findings:

A) On October 3, 2010, two personal support workers transferred a resident from their wheelchair to their bed using an ArjoHuntleigh Maxi Sky 600 ceiling lift and failed to ensure that the lift sling attachment clips were in proper position at all times during the lifting cycle. The result was that the left shoulder clip came undone when the resident's legs were lifted to clear the bed, they fell from the lift to the floor, sustained skin tears to their left arm and right wrist and a fracture to their left femur which required transfer to hospital.

B) In a memo dated October 7, 2010 to all nursing staff from the Administrator, it is noted that the lift sling used when the resident fell had been in use since December 2003 and that the clips were worn, lacking the necessary noticeable resistance of a new clip. Notes taken during a debriefing session for nursing staff about the incident which was held on November 2/2010 and lead by the Administrator indicate that over forty slings that had loose clip were removed from use following the incident.

Inspector ID #:	133

Additional Required Actions:

CO # 1 will be served on the licensee. Refer to the "Order(s) of the Inspector" form.

Signature of Licensee or Representative of Licensee Signature du Titulaire du représentant désigné	Signature of Health System Accountability and Performance Division representative/Signature du (de la) représentant(e) de la Division de la responsabilisation et de la performance du système de santé. Jessica Lapensée
Title: Date:	**Date of Report:** (if different from date(s) of inspection). May 25, 2011

Ontario

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the
Long-Term Care Homes Act, 2007, S.O. 2007, c.8

	☐ Licensee Copy/Copie du Titulaire ☒ Public Copy/Copie Public		
Name of Inspector:	Jessica Lapensée	**Inspector ID #**	133
Log #:	O-001913		
Inspection Report #:	2011_133_2675_11May142546		
Type of Inspection:	Critical Incident		
Date of Inspection:	May 11th, 12th, 2011		
Licensee:	Valley Manor Inc		
LTC Home:	Valley Manor Nursing Home		
Name of Administrator:	Linda Shulist		

To Valley Manor Inc., you are hereby required to comply with the following order by the date set out below:

Order #:	001	**Order Type:**	Compliance Order, Section 153 (1)(a)

Pursuant to: 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.

Order: The licensee must ensure that all staff who use mechanical lifts ensure that lift sling attachment clips are in proper position at all times during a lifting cycle. In addition, the licensee must ensure that all staff use safe transferring devices that meet manufacturer specifications.

Grounds:

A) On October 3, 2010, two personal support workers transferred a resident from their wheelchair to their bed using a ArjoHuntleigh Maxi Sky 600 ceiling lift and failed to ensure that the lift sling attachment clips were in proper position at all times during the lifting cycle. The result was that the left shoulder clip came undone when the resident's legs were lifted to clear the bed, they fell from the lift to the floor, sustained skin tears to their left arm and right wrist and a fracture to their left femur which required transfer to hospital.

B) In a memo dated October 7, 2010 to all nursing staff from the Administrator, it is noted that the lift sling used when the resident fell had been in use since December 2003 and that the clips were worn, lacking the necessary noticeable resistance of a new clip. Notes taken during a debriefing session for nursing staff about the incident which was held on November 2/2010 and lead by the Administrator indicate that over forty slings that had loose clip were removed from use following the incident.

This order must be complied with by:	Immediate

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this(these) Order(s) in accordance with section 163 of the *Long-Term Care Homes Act, 2007.*

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for service for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:.

Director
c/o Appeals Clerk
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
55 St. Clair Ave. West
Suite 800, 8th floor
Toronto, ON M4V 2Y2
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the *Long-Term Care Homes Act, 2007.* The HSARB is an independent group of members not connected with the Ministry. They are appointed by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, with 28 days of being served with the notice of the Director's decision, mail or deliver a written notice of appeal to both:

Health Services Appeal and Review Board and the
Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON
M5S 2T5

Director
c/o Appeals Clerk
Performance Improvement and Compliance Branch
55 St. Claire Avenue, West
Suite 800, 8th Floor
Toronto, ON M4V 2Y2

Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

Issued on this 25th day of May , 2010.	
Signature of Inspector:	Jessica Lapensée
Name of Inspector:	Jessica Lapensée
Service Area Office:	Ottawa Service Area Office