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

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jun 18, 2013	2013_189120_0039	H-000236-13/H-000310-13	Critical Incident System

Licensee/Titulaire de permis

VILLA FORUM
175 FORUM DRIVE, MISSISSAUGA, ON, L4Z-4E5

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

VILLA FORUM
175 FORUM DRIVE, MISSISSAUGA, ON, L4Z-4E5

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

BERNADETTE SUSNIK (120)

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): May 29, 2013

CI #2855-000013-13 and #2855-000017-13

During the course of the inspection, the inspector(s) spoke with the administrator, director of care, environmental services supervisor, health care aides and resident regarding lifts and transfers.

During the course of the inspection, the inspector(s) toured several home areas, observed slings and the various lift equipment, reviewed lift maintenance records, resident plan of care documents, policies and procedures on lifts and transfers, staff education records, written testimonies and the homes investigative documents.

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	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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 :

An employee did not use safe transferring and positioning techniques when assisting a resident in 2013.

One personal support worker (PSW) transferred a resident from a shower chair to a sit to stand lift and applied a support strap and sling as required. During the transfer, the resident verbally expressed that they couldn't hold onto the bars of the lift and began to slide down. A family member who was present during the transfer intervened and prevented the resident from falling and the PSW and another worker assisted the resident into a sitting position on the floor. The resident sustained bruising to the left side of their body which appeared in the vicinity of where the sling and support strap was applied. The resident's care plan requires that two persons (trained employees) assist during any transfer procedure using a mechanical lift. The PSW received lift and transfer training in 2012. The resident's plan of care was readily available to all staff for reference. The management staff took appropriate action following the incident.

Issued on this 18th day of June, 2013

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

B. Susnik