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
Oct 17, 2013	2013_230134_0019	513, 503, 405, 668, 678-13	Critical Incident System

Licensee/Titulaire de permis

MARYCREST HOME FOR THE AGED
659 Brealey Drive, PETERBOROUGH, ON, K9K-2R8

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

ST JOSEPH'S AT FLEMING
659 Brealey Drive, PETERBOROUGH, ON, K9K-2R8

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

COLETTE ASSELIN (134)

Inspection Summary/Résumé de l'inspection

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The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): October 8, 9, 10 and 11, 2013

**During the course of this inspection five critical inspections, log numbers, O-000503-13, O-000513-13,
O-000405-13, O-000668-13 and O-000678-13, were conducted.**

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Unit Manager, several Registered Practical Nurses (RPN), Charge Nurse, Physio Aide, Personal Support Workers (PSW), family members and several residents

During the course of the inspection, the inspector(s) toured Creekside, Pathways and Hilltop units, reviewed the residents' health care records, reviewed the Falls Prevention and Management Program - Policy # 8-41, the Head Injury Routine Policy #8-50, the Resident Assessment Flowchart #9-55, observed a demonstration of the use of a Toileting Sling and the Medi-lift 4 and were shown the Hammock sling.

The following Inspection Protocols were used during this inspection:
Minimizing of Restraining

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 :

1. The licensee failed to comply with the O. Reg 79/10 s. 36, in that Resident #1 was not transferred from bath chair to wheelchair safely.

Based on Resident #1's progress notes of a specified day in May, 2013, two staff members transferred Resident #1 from the bath chair to the wheelchair using a toileting sling instead of the 6 point hammock sling as specified in the plan of care.

Resident #1's plan of care was reviewed. There is an indication in the Transferring section of the care plan, which had been revised on a specified day in January, 2013 that specifies "to use the Sling Medi-lifter Hammock 6 points. The plan of care was reviewed and revised early January, 2013 and this direction to staff was not changed since 2010".

Staff member #S11 was interviewed by inspector #134 regarding Resident #1's transfer from bath chair to wheelchair. Staff member #S11 reported and demonstrated how the "Medi lifter 4" was used with the white 4 point toileting sling. He/She stated that the resident fell out of the sling when the resident suddenly raised his/her arms in the air and fell to the floor. Resident #1 sustained a head injury as a result of the fall and was transferred to hospital.

The progress notes for May, 2013 were reviewed. There is an entry that indicates that at a specified time, "two staff members were in the tub room, assisting resident from bath chair to wheelchair after just completing the resident's bath. The resident was hooked up to the blue and silver toileting sling while sitting in the tub chair. This sling was previously used with the "medi lift 4" to transfer Resident #1 from bed to bath chair and the resident was familiar with the procedure. The blue and grey sling was applied properly with all straps attached to the lift and the seatbelt was done up properly and was tight".

Staff member #14, the routine bath person, was interviewed and indicated that he/she never uses the toileting sling for Resident #1 because the toileting sling is unpredictable. Staff member #14 indicated that he/she checks the kardex in the resident's room as it changes often and always uses the Hammock sling for Resident #1.

As such, Resident #1 was not transferred safely, in that staff did not use the correct sling when transferring Resident #1 from bathchair to wheelchair. [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 residents' assessed and individualized techniques and devices when transferring and positioning residents, to be implemented voluntarily.*

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee failed to comply with the O. Reg 79/10 s. 107 (3) 4 in that the licensee did not report an injury, in respect of which Resident #3 was taken to hospital, no later than one business day after the occurrence of the incident.

Resident #3 had a fall from wheelchair on a specified day in July, 2013 and sustained an injury. The resident was sent to hospital for treatment the same day.

The Director was notified two business days after the incident.

An order was issued July 16, 2013, inspection report #2013_200148_0025 with a compliance date of July 31, 2013. [s. 107. (3) 4.]

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Issued on this 17th day of October, 2013

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

Colette Asselin, LTCH Inspector #134