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
Direction de l'amélioration de la performance et de la conformité

Hamilton Service Area Office
119 King Street West, 11th Floor
HAMILTON, ON, L8P-4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119, rue King Ouest, 11iém étage
HAMILTON, ON, L8P-4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Dec 17, 2012	2012_201167_0007	H-001566-12	Critical Incident System

Licensee/Titulaire de permis

SPECIALTY CARE MISSISSAUGA INC.
400 Applewood Crescent, Suite 110, VAUGHAN, ON, L4K-0C3

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

SPECIALTY CARE MISSISSAUGA ROAD
4350 MISSISSAUGA ROAD, MISSISSAUGA, ON, L5M-7C8

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

MARILYN TONE (167)

Inspection Summary/Résumé de l'inspection

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

---

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

This inspection was conducted on the following date(s): December 12, 2012

During the course of the inspection, the inspector(s) spoke with the Director of Care and the Administrator related to critical incident inspection Log # H-001566 -12

During the course of the inspection, the inspector(s) conducted a review of the health file for the identified resident, reviewed the home's investigation notes related to the incident and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Falls Prevention

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.)	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.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	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. Staff at the home did not ensure that safe positioning techniques were used for an identified resident prior to a fall that resulted in injury.
On the day of the fall, the identified resident was found to have fallen from their Tilt Chair and was laying on the floor in their room.
a) It was noted by the nurse who assessed the resident after the fall occurred that the Tilt Chair was in upright position and not tilted as per the direction in the resident's plan of care. It was reported by staff at the home that a person who was providing assistance to the resident was with the resident at dinner and had also returned the resident back to their room after dinner. This person had already left when the resident sustained the fall.
b) It was noted that prior to the fall, after the resident had been returned to their room by the person who was providing assistance, the resident was observed by a staff member to be sitting in the Tilt Chair in their room and the staff member also noted that the Tilt Chair was in upright position and was not tilted as directed in the resident's plan of care. It was noted that the staff member did not take any action at that time to correct the position of the chair.
c) The home's policy related to Tilt Chairs dated as last reviewed in April 2012, indicated that there are wheelchair description tags on Tilt Chairs. Green edged tags indicate "TILT - reposition every two hours". The red edged tags indicate "DO NOT TILT- please remove my footrests and place my feet on the ground". During an interview with the Director of Care it was confirmed that the the identified resident's Tilt Chair was equipped with a green edged tag requiring that the chair be tilted.
d) The document that the home referred to as the care plan indicated prior to the fall that the resident required application of an external device (Tilt Chair) for prevention of injury to self - characterized by high risk for injury/falls, impaired mobility, poor posture, cognitive impairment. The resident's Tilt Chair was identified in the care plan as a Personal Assistive Service Device (PASD).

A staff member who observed the resident to be incorrectly positioned did not take action to reposition the resident safely prior to them sustaining a fall with subsequent injury. [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 devices or techniques when assisting residents., to be implemented voluntarily.

Issued on this 17th day of December, 2012

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

Marilyn Love