Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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

Sudbury Service Area Office
159 Cedar Street, Suite 603
SUDBURY, ON, P3E-6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159, rue Cedar, Bureau 603
SUDBURY, ON, P3E-6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

Public Copy/Copie du public

Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Sep 9, 15, Oct 14, Nov 23, Dec 5, 9, 2011; Jan 6, 2012	2011_053122_0014	Critical Incident

Licensee/Titulaire de permis

REVERA LONG TERM CARE INC.
55 STANDISH COURT, 8TH FLOOR, MISSISSAUGA, ON, L5R-4B2

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

PINEWOOD COURT
2625 WALSH STREET EAST, THUNDER BAY, ON, P7E-2E5

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

ROSE-MARIE FARWELL (122)

Inspection Summary/Résumé de l'inspection

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

During the course of the inspection, the inspector(s) spoke with the Administrator, Regional Manager of Clinical Services, Documentation Supervisor, Mobility Facilitator/Documentation Nurse

During the course of the inspection, the inspector(s) observed the provision of care and services to the residents of the home, reviewed the resident's health care record and the related critical incident, reviewed various protocols and procedures regarding transfer assessments and related logos.

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

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following subsections:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident;
(b) the goals the care is intended to achieve; and
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. Staff transferred a resident with the sit to stand lift and as the resident stood they became weak and their legs gave out from under them. The resident fell in a downward motion, their body impacted against the lift which resulted in a fracture.

The Administrator reported that staff had used an inappropriate lift due to an error in the signage posted at the resident's bedside. The signage posted at the resident's bedside was a logo of a mechanical lift, with "Sit to Stand, prn" written on the logo in ink.

A staff member was interviewed and explained that the signage posted at the resident's bedside was a logo used to identify the resident's mode of transfer. These logos are placed at all residents' bedsides and identify each residents' assessed mode of transfer. The logos are used as a quick reference for front line staff.

The staff member stated that a reassessment of the resident's transfer needs had been completed shortly prior to the resident's fall. The reassessment was reviewed by the Inspector and identified that the resident required either a "Sit to Stand" lift or a "Hoyer" lift. The type of lift to be used was to be determined based on the resident's weight bearing ability at the time of transfer. Following the assessment, the staff member attempted to update the signage posted at the resident's bedside but discovered that the home had run out of "Sit to Stand" logos. The staff member substituted a "mechanical lift" logo and wrote "Sit to Stand" prn on the logo. The staff member explained that both a "Sit to Stand" lift and a "Hoyer" lift were mechanical lifts; therefore, staff believed that a "Sit to Stand" mechanical lift should be used to transfer the resident.

The Inspector reviewed the resident's health care record and noted that the SALT (Lift and Transfer Assessment) identified that the resident required "a sit to stand /mechanical lift when tired". The assessment did not identify or specify that a "hoyer" mechanical lift could be used. The resident's plan of care identified the use of a "mechanical lift" for transfers, but did not provide clear directions regarding the use of a "sit to stand" lift prn or a "hoyer" lift, prn.

The licensee failed to ensure that the resident's written plan of care set out clear directions to staff and others who provide direct care to the resident. [LTCHA 2007, S.O. 2007, c. 8, s. 6 (1) c]

Issued on this 18th day of January, 2012

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