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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Aug 2, 2016	2016_327570_0015	011952-16, 016976-16, 021083-16	Critical Incident System

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

FENELON COURT
44 WYCHWOOD CRESCENT FENELON FALLS ON K0M 1N0

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

SAMI JAROUR (570)

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): July 25, 26 & 27, 2016

Critical Incident Logs 011952-16, 016976-16 and 021083-16 specific to falls with injury were completed as part of this inspection report.

During the course of the inspection, the inspector(s) spoke with the Executive Director, the Director of Care (DOC), Registered Practical Nurse (RPN), Personal Support Workers (PSW), Office Manager, Program Manager, and the Physiotherapist.

During the course of the inspection, the inspector observed residents, reviewed clinical records, reviewed investigation notes, reviewed policies related to falls and and safety in ambulating lifting and transferring program.

The following Inspection Protocols were used during this inspection:
Critical Incident Response
Falls Prevention
Personal Support Services

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **1 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé 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 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 O. Reg. 79/10, s. 36, by not ensuring staff use safe transferring and positioning devices or techniques when assisting the resident.

Related to Log # 021083-16 for resident #001

Critical Incident Report (CIR) was submitted to the Director, on an identified date specific to an incident involving resident #001 who sustained a fall during transfer. As per the CIR resident #001 sustained an injury to a body part. The resident was assessed by the Nurse Practitioner (NP) who was able to manage the resident's injury at the home. Therefore, the resident was not sent to the hospital following the fall.

Review of clinical records for resident #001 indicated the resident was admitted to the home with multiple diagnoses including cognitive impairment. Records review and interview with personal support workers (PSW) #100 and 101 indicated the resident is totally dependent on staff in all Activities of Daily Living (ADL) and does not participate actively in any ADL.

On July 25, 2016, personal support workers (PSW) #100 indicated to the inspector that he/she and PSW #101 were assisting resident #001 to transfer from bed to a chair using a safety device on an identified date and time. During the transfer, the positioning device attached to the safety device came off from one end causing the resident to fall to the floor.

On July 26, 2016 interview with PSW #101 indicated to the inspector during the transfer and prior to reaching the chair, the resident moved a body part that caused the positioning device to disengage causing the resident to fall.

Both PSWs #100 and #101 indicated to the inspector that RPN #105 spoke to them after the incident that positioning devices with specific colored attachments used with safety devices should not have been used in the home. Both PSWs indicated no awareness not to use those positioning devices prior to this incident.

Review of the licensee's internal incident investigation indicated the positioning device age is more than 10 years, and the device's attachments are easy to come out. The investigation notes indicated: “even though the staff were made aware of specified positioning devices not be used anymore, apparently the staff were using them”.

On July 26, 2016 interview with RPN #105 (staff educator) indicated to the inspector that positioning devices used with safety devices were audited on a specified date prior to the incident; during this audit, specific positioning devices were removed from the home. RPN #105 further indicated that a memo was communicated to staff in the staff communication book indicating that those specific positioning devices should not be used and if any is found to be returned to him/her.

On July 26, 2016 interview with the Executive Director confirmed to the inspector that positioning devices with specific colored attachments were pulled out of service from the home on a specified date prior to the incident and those devices should have not been used by staff.

Therefore, PSWs #100 and 101 did not use safe transferring and positioning devices or techniques when both PSWs assisted resident #001. [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 by ensuring that
- staff are using proper positioning and safety devices when assisting residents;
- a system in place to audit and inspect positioning and safety devices to ensure safety prior to use; and
- a system in place to ensure any changes to the use of safety devices for transferring and positioning of residents are communicated to all staff involved in providing direct care to residents in the home, to be implemented voluntarily.

Issued on this 4th day of August, 2016

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

Original report signed by the inspector.