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

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

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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☐ **Licensee Copy/Copie du Titulaire** ☒ **Public Copy/Copie Public**

Date(s) of inspection/Date de l'inspection	Inspection No/ d'inspection	Type of Inspection/Genre d'inspection
August 30 and 31, 2010	2010_170_270_31Aug072601	Critical Incident L-00374

Licensee/Titulaire
Revera Long Term Care Inc., 55 Standish Court, 8th Floor, Mississauga, Ontario L5R 4B2

Long-Term Care Home/Foyer de soins de longue durée
Forest Heights Long-Term Care Centre, 60 Westheights Drive, Kitchener, Ontario N2N 2A8

Name of Inspector(s)/Nom de l'inspecteur(s)
Dianne Wilbee, LTC Homes Inspector, ID# 170

Inspection Summary/Sommaire d'inspection

The purpose of this inspection was to conduct a Critical Incident inspection related to use of a mechanical lift.

During the course of the inspection, the inspector(s) spoke with: Director of Care, RAI Coordinator, Registered nursing staff, Personal Support Worker.

During the course of the inspection, the inspector(s): Reviewed: Resident record, Critical Incident Reports (multiple residents), Plan of care (identified resident), Use of Mechanical Lifts policy.

The following Inspection Protocols were used in part or in whole during this inspection:

- Critical Incident Response
- Personal Support Services

☒ Findings of Non-Compliance were found during this inspection. The following action was taken:

4 WN
4 VPC

NON- COMPLIANCE / (Non-respectés)

Definitions/Définitions

WN – Written Notifications/Avis écrit
VPC – Voluntary Plan of Correction/Plan de redressement volontaire
DR – Director Referral/Régisseur envoyé
CO – Compliance Order/Ordres de conformité
WAO – Work and Activity Order/Ordres: travaux et activités

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA. 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 suivant constituer un avis d'écrit de l'exigence prévue le paragraphe 1 de section 152 de les foyers de soins de longue durée. Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue durée* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prévue par la présente loi" au paragraphe 2(1) de la loi.

WN #1: The Licensee has failed to comply with LTCHA, 2007, S.O. 2007, c.8, s.6(1)(b),(c)
Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out, (b) the goals the care is intended to achieve; and (c) clear directions to staff and others who provide direct care to the resident.

Findings:
The plan of care for a resident had not been completed. The Resident Admission Assessment/Plan of Care initiated on admission and intended for use for 21 days was in place however did not include goals. One discipline had initiated a computer version of a plan of care with goals; this information was not included on the Resident Admission Assessment/Plan of Care and was not printed to provide access to Personal Support Worker staff who do not have computer access.

Inspector ID #:	170

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 related to the written plan of care, to be implemented voluntarily.

WN #2: 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.

Findings:
Two critical incidents occurred during which two staff members completed separate two-person mechanical lifts alone which does not comply with the home's two-person mechanical lift policy for safe transfer. In the one occurrence a full mechanical lift was used and required intervention of another individual to prevent the sling and resident tipping backwards. The second occurrence involved a sit to stand lift used alone.

Inspector ID #:	**170**

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 staffs' compliance with the home's mechanical lift policy, to be implemented voluntarily.

<table>
<tr><td colspan="2">WN #3: The Licensee has failed to comply with O.Reg. 79/10 s.107(4)4.i, ii
A licensee who is required to inform the Director of an incident under subsection (1) or (3) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident: Analysis and follow-up action, including, the immediate actions that have been taken to prevent recurrence, and the long-term actions planned to correct the situation and prevent recurrence.</td></tr>
<tr><td colspan="2">Findings:
Two staff members did not follow the home's "Use of Mechanical Lifts" policy RC-L-10 resulting in two critical incident reports. The critical incident reports stated neither resident sustained injury however the critical incident reports do not provide analysis and follow-up action specific to immediate actions to prevent recurrence and long-term actions to correct these situations and prevent recurrence.</td></tr>
<tr><td>Inspector ID #:</td><td>170</td></tr>
<tr><td colspan="2">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 post critical incident(s) analysis and follow-up actions to correct the situation and prevent recurrence are identified, to be implemented voluntarily.</td></tr>
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<table>
<tr><td colspan="2">WN #4: The Licensee has failed to comply with O.Reg. 79/10 s.231(b)
Every licensee of a long-term care home shall ensure that, the resident's written record is kept up to date at all times.</td></tr>
<tr><td colspan="2">Findings:
A critical incident occurred and a critical incident report was submitted to the MOHLTC. The report stated the resident was "assessed for injury". Documentation on the resident record did not support completion of a post incident assessment and did not indicate the occurrence of an incident until discussion with the home, at the time of the inspection, when a late entry was documented on the resident record.</td></tr>
<tr><td>Inspector ID #:</td><td>170</td></tr>
<tr><td colspan="2">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 accuracy of information submitted on a critical incident report and completion of a resident assessment and supporting documentation post an incident, to be implemented voluntarily.</td></tr>
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<tr><td colspan="2">Signature of Licensee or Representative of Licensee
Signature du Titulaire du représentant désigné</td><td>Signature of Health System Accountability and Performance Division representative/Signature du (de la) représentant(e) de la Division de la responsabilisation et de la performance du système de santé.
Dianne Wilbee</td></tr>
<tr><td>Title:</td><td>Date:</td><td>Date of Report: (if different from date(s) of inspection).
September 21, 2010 and October 25, 2010</td></tr>
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