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

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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
Jun 3, 2013	2013_168202_0028	T-86-13	Critical Incident System

Licensee/Titulaire de permis

GROVE PARK HOME FOR SENIOR CITIZENS
234 COOK STREET, BARRIE, ON, L4M-4H5

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

GROVE PARK HOME FOR SENIOR CITIZENS
234 COOK STREET, BARRIE, ON, L4M-4H5

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

VALERIE JOHNSTON (202)

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): May 27, 28, 29, 30, 2013

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care, Assistant Director of Care, RAI-Coordinator, Restorative Care Coordinator, Restorative Care Aide, Registered Nursing Staff, Personal Support Workers

During the course of the inspection, the inspector(s) observed the provision of care to residents, reviewed clinical records, reviewed staff education records on lifts and transfers

The following Inspection Protocols were used during this inspection:
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 :

The licensee failed to ensure that staff use safe transferring and positioning techniques when assisting residents. [s.36.]

Resident #001's plan of care directs staff to use a two person Hoyer mechanical lift for all transfers. On an identified date resident #001 was transferred from bed to wheelchair by two staff using a Hoyer mechanical lift and "Long Body Sling'. During the transfer resident #001 slid out of the "Long Body Sling' and onto the floor, sustaining injuries requiring hospitalization, and later passed away.
Staff interviews revealed that Personal Support Worker A (PSWA) and Personal Support Worker B (PSWB) were transferring resident #001 from his/her bed to his/her wheelchair on an identified date . (PSWB) prepared the "Long Body Sling" for use by placing the sling under resident #001 and attaching all the sling straps to the Hoyer mechanical lift leaving the right lower leg strap. (PSWA) entered resident #001's room and attached the remaining right side lower leg strap from the sling to the Hoyer mechanical lift. As (PSWB) walked across resident #001's room to retrieve his/her wheelchair, (PSWA) used the Hoyer mechanical lift to raise resident #001 up from the bed. As resident #001 was raised above the bed, the right side of the sling came off the Hoyer mechanical lift transfer hook, resulting in resident #001 falling to the floor.
An interview with an identified Registered Nurse (RN) revealed that the 'Long Body Sling' may not have been attached to the Hoyer mechanical lift properly. The (RN) indicated that the 'Long Body Sling' has three strap attachments on either side of the sling that correspond to the transfer hooks on either side of the Hoyer mechanical lift. At the time of the incident, the (RN) confirmed that both upper body and mid body straps from the 'Long Body Sling' were attached within one transfer hook on either side of the Hoyer mechanical lift. The (RN) further indicated that if the sling straps are twisted when attached to the Hoyer mechanical lift transfer hooks, there is a chance that the sling straps can come off the Hoyer mechanical lift transfer hooks.
(PSWA) revealed in an interview that both staff members were 'rushing' at the time of the incident and neither staff member were 'engaged' in the process of transferring resident #001. (PSWA) confirmed that he/she had not been trained for the proper usage of the 'Long Body Sling' which involves attaching 3 side straps to the lift. An interview with the Restorative Care Coordinator (RCC) confirmed that the 'Long Body Sling' with three side straps should have been attached to the lift on three separate hooks designated for upper, mid and lower body. The (RCC) revealed that the staff in the home have not been trained on the use of the "Long Body Sling" with three straps and it had been assumed that staff would know how to attach the three straps to the Hoyer Lift.

Staff interviews revealed that the home uses a variety of slings in several sizes and use for sling is dependent upon type of lift and body weight of the resident. Staff indicated that when choosing a sling to use for a mechanical lift transfer, they would use a sling that may be found in a resident's room, on the resident while in the wheelchair or an available sling within the resident home area. Staff indicated that slings are also chosen based on the resident's weight, however staff were unable to identify the specific weight that would correspond to the size of sling to use. An interview with an identified staff member indicated that he/she is able to just pick up a sling and would know what type and size of sling that would work. An interview with the Director of Care confirmed that there are no specifications available for the proper fit of slings used in the home. Staff have been required to use the slings available in the home and was assumed that staff would know which sling is most appropriate.

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: 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:

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; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that the written plan of care set out clear directions to staff and others who provide care to the resident. [s.6.(1)(c)]

Resident #001, #002 and #003's plan of care directs staff to use a two person mechanical lift for transfers. Staff interviews revealed that the home uses several types of slings, including slings of variable sizes. The written plan of care for these residents does not indicate the type or size of sling to use when transferring using a mechanical lift. Staff interviews revealed that when choosing what sling to use on a particular resident, they will choose a sling that they find with the resident or ones placed in their rooms. If a sling is not with the resident they will pick a sling based on the residents weight, however staff were unable to identify the weight that would correspond with a particular size of sling. An interview with the Director of Care confirmed determining the size and type of sling to use on each resident is an area that the home needs to improve upon and that sling size and type is currently not identified in the plan of care. [s. 6. (1) (c)]

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 the written plan of care sets out clear directions to staff and others who provide care to the resident, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:
1. The Residents' Bill of Rights. 2007, c. 8, s. 76. (2).
2. The long-term care home's mission statement. 2007, c. 8, s. 76. (2).
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents. 2007, c. 8, s. 76. (2).
4. The duty under section 24 to make mandatory reports. 2007, c. 8, s. 76. (2).
5. The protections afforded by section 26. 2007, c. 8, s. 76. (2).
6. The long-term care home's policy to minimize the restraining of residents. 2007, c. 8, s. 76. (2).
7. Fire prevention and safety. 2007, c. 8, s. 76. (2).
8. Emergency and evacuation procedures. 2007, c. 8, s. 76. (2).
9. Infection prevention and control. 2007, c. 8, s. 76. (2).
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities. 2007, c. 8, s. 76. (2).
11. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (2).

Findings/Faits saillants :

1. The licensee failed to ensure that staff receive training in the safe and correct use of equipment, including therapeutic equipment, mechanical lifts, assistive aids and positioning aids, that is relevant to the staff member's responsibilities.

Staff interviews revealed that the home uses several types of slings for mechanical lift transfers while assisting residents. Resident #001 fell to the floor during a mechanical lift transfer when the right side of the sling released from the Hoyer mechanical lift. Resident #001 sustained injuries and later passed away. Staff interviews revealed that the 'Long Body Sling' with three loop attachments used for resident #001, during a mechanical lift transfer, may have been hooked incorrectly to the lift resulting in the right side of the sling to come off from the transfer hook on the lift. Staff interviews confirmed that they had received training on the use of the 'Long Body Sling' with three attachments loops. An interview the Restorative Care Coordinator confirmed that staff had not been trained on the use of the 'Long Body Sling' with three attachment loops and it was assumed that staff would know how to use it when transferring residents. [s. 76. (2) 11.]

Issued on this 4th day of June, 2013

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

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	VALERIE JOHNSTON (202)
Inspection No. / No de l'inspection :	2013_168202_0028
Log No. / Registre no:	T-86-13
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jun 3, 2013
Licensee / Titulaire de permis :	GROVE PARK HOME FOR SENIOR CITIZENS 234 COOK STREET, BARRIE, ON, L4M-4H5
LTC Home / Foyer de SLD :	GROVE PARK HOME FOR SENIOR CITIZENS 234 COOK STREET, BARRIE, ON, L4M-4H5
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	TERRY CODLING

To GROVE PARK HOME FOR SENIOR CITIZENS, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

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.

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure all direct care staff receive training on the safe use of all slings and lifts in the home so that all residents are transferred and positioned safely when assisted by staff. Please submit plan to valerie.johnston@ontario.ca by June 21, 2013.

Grounds / Motifs :

1. The licensee failed to ensure that staff use safe transferring and positioning techniques when assisting residents. [s.36.]

Resident #001's plan of care directs staff to use a two person Hoyer mechanical lift for all transfers. On an identified date resident #001 was transferred from bed to wheelchair by two staff using a Hoyer mechanical lift and "Long Body Sling'. During the transfer resident #001 slid out of the "Long Body Sling' and onto the floor, sustaining injuries requiring hospitalization, and later passed away.
Staff interviews revealed that Personal Support Worker A (PSWA) and Personal Support Worker B (PSWB) were transferring resident #001 from his/her bed to his/her wheelchair on an identified date . (PSWB) prepared the "Long Body Sling" for use by placing the sling under resident #001 and attaching all the sling straps to the Hoyer mechanical lift leaving the right lower leg strap. (PSWA) entered resident #001's room and attached the remaining right side lower leg strap from the sling to the Hoyer mechanical lift. As (PSWB) walked across resident #001's room to retrieve his/her wheelchair, (PSWA) used the Hoyer mechanical lift to raise resident #001 up from the bed. As resident #001 was raised above the bed, the right side of the sling came off the Hoyer mechanical lift transfer hook, resulting in resident #001 falling to the floor.
An interview with an identified Registered Nurse (RN) revealed that the 'Long

Body Sling' may not have been attached to the Hoyer mechanical lift properly. The (RN) indicated that the 'Long Body Sling' has three strap attachments on either side of the sling that correspond to the transfer hooks on either side of the Hoyer mechanical lift. At the time of the incident, the (RN) confirmed that both upper body and mid body straps from the 'Long Body Sling' were attached within one transfer hook on either side of the Hoyer mechanical lift. The (RN) further indicated that if the sling straps are twisted when attached to the Hoyer mechanical lift transfer hooks, there is a chance that the sling straps can come off the Hoyer mechanical lift transfer hooks.
(PSWA) revealed in an interview that both staff members were 'rushing' at the time of the incident and neither staff member were 'engaged' in the process of transferring resident #001. (PSWA) confirmed that he/she had not been trained for the proper usage of the 'Long Body Sling' which involves attaching 3 side straps to the lift. An interview with the Restorative Care Coordinator (RCC) confirmed that the 'Long Body Sling' with three side straps should have been attached to the lift on three separate hooks designated for upper, mid and lower body. The (RCC) revealed that the staff in the home have not been trained on the use of the "Long Body Sling" with three straps and it had been assumed that staff would know how to attach the three straps to the Hoyer Lift.
Staff interviews revealed that the home uses a variety of slings in several sizes and use for sling is dependent upon type of lift and body weight of the resident. Staff indicated that when choosing a sling to use for a mechanical lift transfer, they would use a sling that may be found in a resident's room, on the resident while in the wheelchair or an available sling within the resident home area. Staff indicated that slings are also chosen based on the resident's weight, however staff were unable to identify the specific weight that would correspond to the size of sling to use. An interview with an identified staff member indicated that he/she is able to just pick up a sling and would know what type and size of sling that would work. An interview with the Director of Care confirmed that there are no specifications available for the proper fit of slings used in the home. Staff have been required to use the slings available in the home and was assumed that staff would know which sling is most appropriate. (202)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 31, 2013

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 3rd day of June, 2013

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : Valerie Johnston

Service Area Office / Bureau régional de services : Toronto Service Area Office