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

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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
Sep 9, 2013	2013_189120_0060	H-000568-13	Complaint

Licensee/Titulaire de permis

THE REGIONAL MUNICIPALITY OF NIAGARA
2201 ST. DAVID'S ROAD, THOROLD, ON, L2V-4T7

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

LINHAVEN
403 Ontario Street, St. Catharines, ON, L2N-1L5

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

BERNADETTE SUSNIK (120)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): August 29, 30 and September 5, 2013

During this inspection, non-compliance was identified related to a failure to report a critical incident to the Director under s.24(1) under the Long-term Care Homes Act. The evidence for the non-compliance can be found on a follow-up inspection report #2013-214146-0043 which was conducted at the same time.

During the course of the inspection, the inspector(s) spoke with the administrator, associate director of care, director of care and personal support workers.

During the course of the inspection, the inspector(s) reviewed training materials, lift maintenance and inventory logs, lift and transfer policies and procedures, observed lifts and slings throughout the building and had personal support workers demonstrate use of sling and floor lift.

The following Inspection Protocols were used during this inspection:
Critical Incident Response

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 :

Staff did not use safe transferring and positioning techniques when assisting a resident in 2013.

Two personal support workers were transferring a resident from a wheelchair to their bed using a mechanical lift. The resident was dependent on staff for all care requirements, including transfers. The sling, which has four plastic clips, one on each corner, was required to be clipped onto four individual metal pegs located on the mechanical floor lift. Each worker was required to attach two of the clips as they stood on either side of the lift. As the resident was being lifted into the air off their chair, their right leg fell towards the floor as the sling clip for their right leg was either not attached or was not adequately clipped onto the peg.

The resident's upper body began to slide out of the sling as the leg was not secured and one of the workers tried to hold onto the resident's leg and torso while the other worker tried to lower the lift. Unfortunately, the worker could not sustain the weight of the resident and they let the resident go. The resident as a result hit their head on the base of the lift, sustaining several lacerations.

Both workers had received lift and transfer training and had used the sling and lift many times prior to the incident. The management of the home conducted an internal review of the incident and suspended both workers.

As per the manufacturer of the sling, if the clip was properly attached to the peg, the resident's weight should have ensured that the clip stayed on the peg. After interviewing both workers and having one of the workers conduct a re-enactment of the incident, the resident fell from the lift as a result of improper use of equipment and associated accessories. [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 18th day of September, 2013

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