# Ministry of Health and Long-Term Care

# Ministère de la Santé et des Soins de longue durée

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

## 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**
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## Public Copy/Copie du public

| Report Date(s) / Date(s) du Rapport | Inspection No / No de l'inspection | Log # / Registre no | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Mar 12, 2013 | 2013_198117_0004 | O-001493-12 + 3 | Critical Incident System |

**Licensee/Titulaire de permis**

UNITED COUNTIES OF PRESCOTT AND RUSSELL
59 Court Street, Box 304, L'Orignal, ON, K0B-1K0

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

RESIDENCE PRESCOTT et RUSSELL
1020, Cartier Boulevard, HAWKESBURY, ON, K6A-1W7

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

LYNE DUCHESNE (117)

## 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): March 6 and 7, 2013, on site at the Long Term Care Home.

Please note that four (4) Critical Incident Inspections were conducted during this inspection: Log #O-001493-12, #O-001547-12, #O-002066-12 and #O-000082-13.

During the course of the inspection, the inspector(s) spoke with the home's Administrator, two Nursing Care Coordinators, several Registered Practical Nurses (RPN), several Personal Support Workers (PSWs) and to several residents.

During the course of the inspection, the inspector(s) reviewed the health care records of four identified residents, observed resident care and services, examined a tub room ceiling lift, Hammock 6 Sling and Hygienic Sling, reviewed staff lift training schedule, reviewed home's post fall internal incident reports for identified residents, and reviewed four Critical Incident Reports.

The following Inspection Protocols were used during this inspection:
Falls Prevention

Hospitalization and Death

Personal Support Services

Findings of Non-Compliance were found during this inspection.

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend | Legendé |
| WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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.)<br><br>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.<br><br>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 in that the home did not ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

Resident #2 plan of care identifies that the resident requires the use of a mechanical lift for transferring and repositioning. Two staff members are to be present at all times during transfers and repositioning. Resident#2 has a Hammock 6 Sling identified for their personal use for ceiling lift transfers.

On a specified day in July 2012, two PSWs were assisting Resident #2 with their bath. The resident was brought to the tub room and positioned for the bath with the aid of the Hammock 6 Sling and ceiling lift. The sling was removed for the bath and placed on a hook behind the tub room door.

Post bath, the PSWs positioned Resident #2 in a Hygienic Sling, that was also stored on a hook behind the tub room door. One of the 2 PSWs had to leave but was replaced by a third PSW. The two remaining PSWs connected the Hygienic Sling to the tub room's ceiling lift and proceeded to lift and transfer the resident from the tub chair to a wheelchair.

During the transfer, Resident #2's upper body started to slide out of the Hygienic Sling. One PSW held on to the resident's legs and the other tried to support the resident's upper body. However, the Resident still fell to the tub room floor. Resident #2 was immediately assessed and transferred to hospital. Resident #2 sustained an injury and was returned to the home that same day. The PSWs immediately reported the incident to the unit RN that they had applied the incorrect sling (Hygenic Sling) for the resident's transfer. The Hygienic Sling is only to be used with a Sit to Stand lift and not with a ceiling lift.

The PSW staff did not use safe transferring devices and techniques while assisting Resident #2 during a mechanical lift transfer. They used the incorrect transfer sling for a ceiling lift which resulted in the resident falling out of the transfer sling and sustaining an injury. [log # O-001547-12] [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 all staff know which transfer sling is to be used with specific mechanical lifts and that they use the correct transfer slings, as identified in residents' plan of care, when assisting residents with their transfers and repositioning, to be implemented voluntarily.***

**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. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).**

**Findings/Faits saillants :**

1. The Licensee failed to comply with the LTCHA s. 6 (7) in that the care set out in the plan of care was not provided for two identified residents as specified in their plans of care.

Resident #1 is identified as being at risk for falls. The plan of care identifies that Resident #1 is to have a lap belt restraint applied when the resident is seated in their wheelchair. On a specified day in June 2012, Resident #1 was seated in their wheelchair after receiving a bath. Resident #1 fell out of their wheelchair, sustaining an injury. At the time of the incident, the two PSWs who had positioned Resident #1 in the wheelchair, immediately reported to the unit RPN that they had not applied the resident's lap belt restraint as identified in the resident's plan of care. [Log# O-001493-12] [s. 6. (7)]

2. Resident #3 is identified as being at risk for falls. The plan of care indicates that the resident is to be toileted every shift, with staff assistance and that the Resident #3 is not to be left unattended when being toileted.

On a specified day in September 2012, Resident #3 was being toileted by a PSW staff member. The PSW was in attendance, monitoring Resident #3. A call bell rang and the PSW left the Resident's side to respond to the call bell. The PSW returned to find that Resident #3 had fallen off the toilet. The resident was assessed, the POA and attending physician were notified of the resident's fall. 911 was called and Resident #3 was transferred to hospital for further assessment. Resident #3 was diagnosed with a fracture. At the time of the incident, the PSW who had positioned Resident #3 on the toilet, immediately reported to the unit RN that they had left the Resident unsupervised while on the toilet, contrary to what was identified in the resident's plan of care.

The PSW did not provide care to the Resident as specified in the plan when they left the Resident unattended on the toilet to respond to a call bell which resulted in Resident #3's fall and injury. [Log# O-002066-12] [s. 6. (7)]

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Issued on this 12th day of March, 2013

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

Lyne Duchesne #117