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 apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Feb 27, 2015	2015_330573_0004	O-000713-14/O-001216-14	Critical Incident System

Licensee/Titulaire de permis

TOWNSHIP OF OSGOODE CARE CENTRE
7650 SNAKE ISLAND ROAD METCALFE ON K0A 2P0

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

TOWNSHIP OF OSGOODE CARE CENTRE
7650 SNAKE ISLAND ROAD METCALFE ON K0A 2P0

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

ANANDRAJ NATARAJAN (573)

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): January 21 and 22, 2015.

During the course of the inspection, the inspector conducted two critical incident inspections log #O-000713-14 and log #O-001216-14.

The inspector reviewed the resident's health care records, including plans of care, progress notes, and clinical assessments. Inspector reviewed the home's policy and procedures for Mechanical Lifting & Sling Safety Protocol and Falls Prevention & Management. In addition, the inspector also observed resident care and resident rooms.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the Assistant Director of Care (ADOC), a registered nurse (RN),a registered practical nurse (RPN), several personal supports workers (PSW) and a housekeeping staff.

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

During the course of this inspection, Non-Compliances were issued.
- **2 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 has failed to ensure that staff use safe transferring and positioning techniques when assisting Resident #01 for transfers. [O-000713-14]

Resident # 01's Fall Incident Report on a specific day in July, 2014 indicated that Resident #01 sustained a hematoma with skin abrasion to the left occipital area while a

PSW Staff #101 and Housekeeping Staff #102 transferred Resident #01 from a wheel chair to bed using the mechanical lift. During the transfer, Resident's left leg came out of the sling as the sling detached from the left clip of the mechanical lift causing resident to slip from the sling.

A review of the Home's policy entitled Mechanical Lifts Protocol VII-G-40.40(I) which states that Staff must check that the appropriate sling for the lift and that sling clips are tight and secure. Under Procedure, it indicates staff to raise the resident slowly and the staff are to reassure and ensure all is safe. In the Home's policy Use of sling for a Mechanical Lift VII-G-40.40(h) under application of the sling for mechanical lift, it states to use two staff to apply the sling on each side.

On January 21, 2015 PSW Staff #101 was interviewed by Inspector #573 regarding Resident #001's transfers on a specific day in July, 2014. PSW Staff #101 indicated on a specific day in July, 2014 approximately before lunch time she and a housing keeping Staff #102 transferred Resident #001 from wheel chair to bed. The PSW Staff #101 mentioned that during the transfer Resident #001 lifted her/his left leg up and towards the lift sling clip, which detached the left leg sling clip from the lift. This was not noticed or observed by the staffs until Resident's left leg slip out of the sling.

During an interview on January 21, 2015 Housekeeping Staff #102 stated to the inspector that on a specific day in July, 2014 PSW Staff #101 called her to Resident #01's Room to spot transfer resident from wheel chair to bed using a mechanical lift. The Housekeeping Staff #102 mentioned that the PSW Staff #101 had already applied the sling to Resident #01 and attached the sling clips to the mechanical lift without her assistance. Further the Staff #102 stated that she was behind the Resident 01's wheel chair and did not notice if the sling clips were attached to the mechanical Lift.

Inspector #573 spoke with Assistant Director of Care (ADOC) who is the lead for Lifts and Transfers (Move-It team)and indicated that Housekeeping staff can help in spot transfers if they had the training in the Transfers and Lifts. Inspector #573 requested for Staff #102 education training in relation to Lifts and transfers and the Home was not able to provide a copy of Staff #102 training in Lifts and transfers.

On January 21, 2015 Inspector #573 spoke with the Director of Care (DOC) who mentioned that the expectation of the staffs while transferring resident in mechanical lift is to make sure that the lift sling clips are attached properly to the lift and to ensure all is safe while transferring resident. Further the DOC confirmed with Inspector #573 that on

an identified date in July, 2014 the Staff #101 and #102 failed to use safe transferring techniques while transferring Resident #01. [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 that the staffs ensure the mechanical lift sling clips are attached properly to the lift and staffs to reassure all is safe while transferring residents using a mechanical lift., to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that when the resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment been conducted using a clinically appropriate assessment instrument that is specifically designed for falls. [O-001216-14]

Critical Incident Report (CIS) #2747-000008-14 indicates that Resident #02 had a fall on a specific day in September, 2014 and the resident sustained a fracture to the nose and on a specific day in October, 2014 Resident #02 experienced another fall that resulted in Fracture Right Hip for which resident was taken to the hospital. The fall on October, 2014 resulted in significant change in the Resident's health status.

The home's policy on Falls Prevention and Management Program (VI-G-10.58) under Post Falls Assessment directs that the resident care plan must be re-evaluated using the Fall Risk Assessment tool.

A review of the Resident #02 health care record identifies that the resident is at risk for falls, however there was no post fall assessment using the Fall Risk Assessment tool found in the Resident health record for any of these falls.

On January 22, 2015 Inspector #573 spoke with Assistant Director of Care (ADOC) who is the lead for Fall Prevention & Management stated that for any post falls that resulted in any change in resident's health status, the expectation of the Registered staff is to complete a post fall assessment using a Fall Risk Assessment tool in the Point Click Care.

After reviewing the health records of Resident #02 with the Inspector #573, the ADOC stated that there was no post fall assessment done using a Fall Risk Assessment tool in the Resident #02 health record for either of the falls. [s. 49. (2)]

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Issued on this 27th day of February, 2015

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

Original report signed by the inspector.