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
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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
Aug 9, 2013	2013_179103_0038	O-000659-13	Complaint

Licensee/Titulaire de permis

TRILOGY LTC INC.
100 Milverton Drive, Suite 700, MISSISSAUGA, ON, L5R-4H1

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

TRILOGY LONG TERM CARE
340 McCowan Road, SCARBOROUGH, ON, M1J-3P4

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

DARLENE MURPHY (103)

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 1, 2, 8, 2013

During the course of the inspection, the inspector(s) spoke with Personal Support Workers (PSW), Registered Practical Nurses (RPN), a Registered Nurse (RN), the Director of Care (DOC) and the Administrator.

During the course of the inspection, the inspector(s) reviewed the resident health care record.

The following Inspection Protocols were used during this inspection: Continence Care and Bowel Management

Falls Prevention

Findings of Non-Compliance were found during this inspection.

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 comply with O. Reg 79/10 s. 36 whereby staff did not use safe transferring techniques when assisting a resident.

On an identified date, Resident #1's family member requested the resident be transferred to bed. Resident #1's condition had deteriorated and according to staff, the resident was unable to transfer from the wheelchair to the bed with the usual assistance of staff due to a lack of strength in his/her arms and legs.

The staff determined the resident would require a mechanical lift to get into bed. S#105 was interviewed and stated the resident was slumped down in the wheelchair. Two staff members were unable to apply the transfer sling properly as a result of the resident's position. Resident #1 was transferred using a hoyer lift while one staff member supported the resident's upper body and the second staff member supported the resident's lower body and legs. As the resident was positioned over the mattress, S#105 stated the resident's bottom slipped out of the sling onto the bed.

The resident was assessed and sustained no injuries as a result of the incident. The resident was sent to hospital for reassessment of his/her deteriorating condition.

At the time of the inspection, the home was working with the lift provider to obtain a sling that would be safe during the transfer of a resident with limited ability to be properly positioned. [s. 36.]

Issued on this 9th day of August, 2013

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