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
Aug 9, 2013	2013_230134_0009	426, 654, 466, 2438, 2437-13	Critical Incident System

Licensee/Titulaire de permis

THE CORPORATION OF THE CITY OF KAWARTHA LAKES
26 Francis Streeet, LINDSAY, ON, K9V-5R8

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

VICTORIA MANOR HOME FOR THE AGED
220 ANGELINE STREET SOUTH, LINDSAY, ON, K9V-4R2

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

COLETTE ASSELIN (134)

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): July 24, 25 and 26, 2013

During the course of this inspection, 5 critical incident inspections were conducted (log# O-002437-12, O-002438-12, O-000426-13, O-000466-13, O-000654 -13) as well as one complaint inspection (log#O-000500-13)

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), several registered nurses (RN), several Registered Practical Nurses (RPN), Coordinator of Staff Development, several Personal Support Workers (PSW) and several residents.

During the course of the inspection, the inspector(s) reviewed the identified residents' health records, the licensee's Abuse and Neglect Policy # VII-G-10-00 and the licensee's Lift Procedures Policy # VII-G-40.40.

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

Dignity, Choice and Privacy

Prevention of Abuse, Neglect and Retaliation

Responsive Behaviours

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 :

1. The licensee failed to comply with O. Reg 79/10 s. 36, in that, safe transferring and positioning devices or techniques were not used when assisting Resident #9 and Resident #5 during their transfers from chair to toilet.

Resident #9's plan of care was reviewed and there is an entry specifying "the resident is encouraged to maintain maximum level of participation during toileting process. Two staff is to provide weight bearing support to transfer side by side and that the resident is able to participate in the transfers".

On a specified date in November, 2013, Resident #9's substitute decision maker (SDM) reported to the DOC that staff members #S80 and #S81 used the Sara lift on Resident #9 in a way which caused the resident to tear up and flinch. The resident had a deformed finger, which would have made it painful and difficult for this resident to hold on to the Sara lift's handle bars and support body weight.

Staff member #S80 was interviewed and reported that the Sara lift was used to transfer Resident #9 from chair to toilet because the co-worker was on modified duty due to an injury and would not have been able to assist with the two person "side-by-side" transfer.

According to staff member #80, the resident had a deformity to one finger, which made it difficult for the resident to grab onto the Sara lift's handle bar comfortably with the affected hand.

On a specified date in September, 2012, there was an incident where Resident #5 was transferred by two staff members using the Sara lift. The progress notes were reviewed and there is an entry indicating the resident's knees buckled and as a result the resident sustained massive bruising to both shins.

The DOC and ADOC were interviewed July 24, 2013 as it relates to the licensee's transfer and zero-lift policy. They indicated that when a resident is observed by the PSW to be too weak to stand then staff can graduate to a lifting device to transfer the resident.

As such, both residents #5 and #9 were not able to support their weight, therefore the use of the Sara lift was not the appropriate choice as the residents would have needed to be able to follow instructions and support their weight to be able to use the

Sara lift safely and comfortably.

Furthermore, staff members #S87 and #S89, who work on Victoria House, were interviewed by Inspector #134 regarding Resident #5's transfer techniques. Both reported that a "chair lift" transfer method, is normally used for Resident #5, because the resident is tiny and does not weigh much. They described the chair-lift transfer as follows: 2 staff lift the resident by placing one arm each behind the resident's back and one arm each underneath the resident's legs to form a chair-like transfer.

The Education Coordinator was interviewed by the Inspector on July 26, 2013 and indicated the home has a zero-lift policy and that the chair lift method is never to be used.

As such, safe transferring and positioning devices or techniques were not used when assisting Resident #5 and Resident #9 during their transfers from chair to toilet. [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 each resident is properly assessed by an interdisciplinary team when an alternate method of transferring is considered, to ensure it is safe based on the resident's individual needs and capabilities and ensure the licensee's zero-lift policy is adhered to, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

1. The licensee failed to comply with the O. Reg 79/10 s. 98, in that the licensee did not notify the appropriate police force immediately when an incident of non-consensual sexual touching between one resident toward another was witnessed by a staff member.

The O. Reg 79/10 defines sexual abuse as any non-consensual touching, behaviour, or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member.

On a specified date in July, 2013, Resident #8 was observed touching co-resident #11 inappropriately. The incident of sexual nature was not consensual.

The licensee became aware of the non-consensual sexual touching between Resident #8 towards Resident #11 on a specified date in July, 2013. The licensee immediately took action in response to the incident but did not call the appropriate police force. [s. 98.]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition. O. Reg. 79/10, s. 107 (3).
2. An environmental hazard, including a breakdown or failure of the security system or a breakdown of major equipment or a system in the home that affects the provision of care or the safety, security or well-being of residents for a period greater than six hours. O. Reg. 79/10, s. 107 (3).
3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).
5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee failed to comply with the O. Reg 79/10 s. 107 (3) (4), in that the Director was not informed within one business day, of an incident where a resident was injured following a fall and sent to hospital.

As per a critical incident report, Resident #1 pushed Resident #10 to the floor. Based on the critical incident and progress notes, Resident #10 appeared to have lost consciousness for 4 minutes. Upon further assessment Resident #10 was complaining of pain in the left hip and was taken to hospital for assessment and returned to the home with no fracture.

The Critical Incident report was completed within 10 days and sent to the Director but the Director was not notified within one business day after the occurrence of the incident, as per legislative requirement. [s. 107. (3)]

Issued on this 13th day of August, 2013

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

Cassell, LTCH Inspector #134