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 |
|---|---|---|---|
| Jun 18, 2013 | 2013_163189_0011 | T-151-13 | Complaint |

**Licensee/Titulaire de permis**

FRIULI LONG TERM CARE
7065 Islington Avenue, Woodbridge, ON, L4L-1V9

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

VILLA LEONARDO GAMBIN
40 Friuli Court, Woodbridge, ON, L4L-9T3

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

NICOLE RANGER (189)

## 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): May 8, 9, 13, 2013**

**During the course of the inspection, the inspector(s) spoke with Director of Care, Registered Staff, Personal Support Workers**

**During the course of the inspection, the inspector(s) Conducted walk through of resident and common areas**
**Reviewed health care records**

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

**Findings of Non-Compliance were found during this inspection.**

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Legendé<br><br>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 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 ensure that the care set out in the plan of care is provided to resident # 3 as specified in the plan.

The Plan of care for resident # 3 in March 2012 states the resident requires 2 staff for pivot transfers. Resident #3 was not transferred with 2 direct care staff as required.

On March 17, 2012, the PSW pivot transferred resident from the toilet without a second person assisting. During the transfer the resident sustained an injury to his/her right ankle. [s. 6. (7)]

***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 the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.***

**WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system**

**Specifically failed to comply with the following:**

**s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,**
**(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).**
**(b) is on at all times; O. Reg. 79/10, s. 17 (1).**
**(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).**
**(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).**
**(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).**
**(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).**
**(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that the home is equipped with a resident-staff communication and response system that (a) can be easily seen, accessed and used by residents, staff, visitors at all times.

On May 9, 2013 inspector walked into a resident's room and observed call bell by the wall and inaccessible to resident #4. Resident reported to inspector that he/she requested assistance 2 hours ago and staff did not come to assist him/her. Resident states that he/she has to wait a long time for assistance. Inspector provided call bell to resident and resident activated call bell. The call bell was not answered by staff for another 10 minutes. [s. 17. (1)]

**WN #3: 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 ensure that staff use safe transferring and positioning techniques when assisting residents.

Record review and staff interviews indicated that in March 2012, resident # 3 required 2 staff for pivot transfers. Resident #3 was not transferred with 2 direct care staff as required.

On March 17, 2012, the PSW pivot transferred resident from the toilet without a second person assisting. During the transfer the resident sustained an injury to his/her right ankle. [s. 36.]

**WN #4: 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):**
**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 ensure that the Director is informed of the following incident in the home no later than one business day after the occurrence of the incident, followed by the report : (4) An injury in respect of which a person is taken to hospital.

On March 17, 2012, the PSW pivot transferred resident #3 from the toilet without a second person assisting. During the transfer the resident sustained an injury to his/her right ankle. The resident was sent to the hospital on March 17, 2012 and returned to the home on March 18, 2012.

The Ministry Of Health and Long Term Care Director was not notified of the resident's transfer to hospital. [s. 107. (3) 4.]

**Issued on this 18th day of June, 2013**

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

Nicole Lamp