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 apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jan 4, 2016	2015_405189_0019	015897-15	Critical Incident System

Licensee/Titulaire de permis

Schlegel Villages Inc
325 Max Becker Drive Suite 201 KITCHENER ON N2E 4H5

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

THE VILLAGE OF HUMBER HEIGHTS
2245 Lawrence Avenue West ETOBICOKE ON M9P 3W3

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 Critical Incident System inspection.

This inspection was conducted on the following date(s): November 19, 20, 2015.

This Critical Incident Inspection is related to a critical incident the home submitted related to transferring and positioning.

During the course of the inspection, the inspector(s) spoke with Assistant General Manager (AGM), Director of Care (DOC), Physician, Neighbourhood Coordinator, Kinesiologist, registered staff, maintenance staff, personal support workers.

The inspector conducted a tour of the home, observations of resident bed system, record review of clinical health records, reviewed relevant home policies and procedures.

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

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **2 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 LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident’s linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

On an identified dated in June 2015, resident #001 required to be transferred out of his/her bed into his/her wheelchair as the staff needed to replace his/her bed. PSW #105, who was assigned to care for the resident, reported to the inspector that her/she and PSW #106 assisted the resident with personal care , then applied the sling and transferred the resident from the bed into his/her wheelchair using the lift. Once the resident was sitting in his/her wheelchair beside the bed, PSW #106 reported the wheelchair quickly moved forward into the bed frame and an identified part of the resident's body struck the metal knob on the bed frame. PSW #106 and PSW #105 reported they heard the resident say “oww, oww” and they then observed an injury on an identified area of the body. Interviews with registered staff #101, PSW #100, PSW #105 and PSW #106 revealed upon closer observation of the bed, there was a missing black plastic cap that was covering a round edge of the bed frame handle, with the steel end of the bed frame handle exposed.

Interview with Director of Care (DOC) and maintenance staff #104, revealed that on an identified date in June 2015, maintenance staff #104, conducted an audit of the residents' bed on all floors and identified the beds that had missing black plastic caps from the bed frame. Maintenance staff #104 reported that he informed the Assistant General Manager (AGM) of the missing caps and that some of the caps were replaced on the identified beds.

On an identified date in November 2015, the inspector conducted an observation of all resident beds on an identified unit and found 6 resident beds with missing black plastic caps from the bed frame. The inspector observed 1 out of the 6 beds found to be missing the black plastic caps, similar to the missing bed frame caps that was missing from resident #001 bed frame handle, leaving the steel end of the bed frame handle exposed.

Interviews and observations with the AGM, DOC and maintenance staff #104 confirmed the missing black plastic caps on the 6 identified resident beds and the AGM informed the inspector that they will be replaced immediately. [s. 15. (2) (c)]

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 he home, furnishings and equipment are maintained in a safe condition and in a good state of repair, to be implemented voluntarily.

WN #2: 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 devices or techniques when assisting residents.

Review of the written plan of care for resident #001 dated June 2015, reveals that the resident requires mechanical or ceiling lifts for transfers and uses a wheelchair for mobility. Record review reveals that resident was mostly bed bound as there was a significant change in health status from June 2015.

On an identified date in June 2015, resident #001 required to be transferred out of his/her bed into his/her wheelchair as the staff needed to replace his/her bed. PSW #105, who was assigned to care for the resident, reported to the inspector that he/she and PSW #106 assisted the resident with personal care , then applied the sling and transferred the resident from the bed into the wheelchair using the lift. Once the resident was in the wheelchair beside the bed, PSW #106 reported the wheelchair quickly moved forward into the bed frame and an identified part of the resident's body struck a metal knob on the bed frame. PSW #106 and PSW#105 reported they heard the resident say “oww, oww” and they then observed an injury on an identified area of the body. PSW #105 states that he/she called the nurse to assess and registered staff #101 came into the room to assess the resident. The resident was assessed by the staff and sent to the hospital. The resident was found to sustain a large blood loss from the injury.

PSW #105 reported to the inspector that while the resident was transferred from the bed to the wheelchair, the wheelchair was not locked, and the PSW was unsure if the resident moved the wheelchair forward after being transferred. Interviews with registered staff #101, PSW #100, PSW #105 and PSW #106 revealed upon closer observation of the bed, there was a missing black plastic cap that was covering a round edge of the bed frame handle, with the steel end of the bed frame handle exposed. The bed frame handle was found to have blood covering the area.

Interview with Unit Coordinator #103, registered staff #101 and PSW #105 confirmed that it was reported that the wheelchair was not locked during the transfer. The Director of Care confirmed the PSW did not use safe transferring techniques when assisting the resident, and the resident sustained an injury. [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 staff use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

Issued on this 3rd day of February, 2016

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

Original report signed by the inspector.