Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministére de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

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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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Feb 7, 8, 9, 2012	2012_080189_0006	Critical Incident

Licensee/Titulaire de permis

601092 ONTARIO LIMITED
429 WALMER ROAD, TORONTO, ON, M5P-2X9

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

VERMONT SQUARE
914 BATHURST STREET, TORONTO, ON, M5R-3G5

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 inspection.

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Nursing, Day Nurse Manager, Registered Staff

During the course of the inspection, the inspector(s) Reviewed health care records
Reviewed home's policy on Transfers/Mechanical Lifts

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	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.)	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.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	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 subsections:

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 :

Resident did not receive the required care as indicated in the plan of care when transferred with a mechanical lift

Plan of care for resident states that resident requires two person transfer with mechanical lift. Personal Support Worker (PSW)transferred the resident without a second person assisting using a mechanical lift. PSW conducted a unsafe transfer that resulted in resident fracturing the right femur.

PSW reported to Day Nurse Manager that they did not refer to the plan of care prior to providing care for the resident to ensure that resident was transferred safely. PSW employment was terminated as the plan of care was not followed.

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 :

Resident sustained a serious injury during transfer when staff transfer resident unsafely.

Plan of care for resident indicates the following: "TRANSFERS: Resident need two person physical assistance with mechanical lift aid (hoyer lift)".

Personal Support Worker (PSW) transferred the resident from bed to wheelchair using a mechanical Hoyer lift without a second person as directed by the plan of care.

Plan of care notes the resident's inability to weight bear. Home's Transfer Policy E-20 states "the resident requiring the use of a mechanical lift and/or ceiling lift will be assisted by two staff to promote both resident and staff safely".

PSW transferred resident from bed while resident was holding on to saskapole. Resident unable to stand and weight bear, and while transferring to the wheelchair, resident slid down the saskapole and fell to the floor with legs trapped under the bed. Resident sustained a fractured right femur.

Issued on this 27th day of February, 2012

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