Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Aug 25, 2021	2021_836766_0014	005448-21, 006791-21, 010238-21	Critical Incident System

Licensee/Titulaire de permis

Caressant-Care Nursing and Retirement Homes Limited
264 Norwich Avenue Woodstock ON N4S 3V9

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

Caressant Care Harriston
24 Louise Street P.O. Box 520 Harriston ON N0G 1Z0

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

KATY HARRISON (766)

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): August 9-13, 16-17, 2021.

The following intakes were completed within the inspection:

Log #005448-21, related to falls,

Log #006791-21, related to falls,

Log #010238-21, related to falls.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Resident Care Coordinator/Infection Prevention and Control Lead (RCC/IPAC), Environmental Services Supervisor (ESS), Registered Nurse (RN), Registered Practical Nurse (RPN), Personal Support Worker (PSW), Physiotherapy Assistant (PTA) and a Housekeeper.

The Inspector also toured the home, observed the provision of resident care, staff-resident interactions, reviewed resident clinical records and critical incident system reports.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control
Personal Support Services
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **1 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	Légende 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 ensure that a Personal Support Worker (PSW) transferred a resident using safe transferring techniques.

A PSW transferred a resident by themselves instead of with two staff members, as indicated in the resident's plan of care. During the transfer the resident lost their balance and had to be lowered to the floor. The next morning the resident complained of pain and was transferred to hospital where they were diagnosed with an injury.

An investigation was completed by the home,which identified that the PSW transferred the resident by themselves instead of with two staff members.

As a result of the PSW using unsafe transferring techniques, the resident sustained actual harm.

Sources: Observations; clinical record review; critical incident report; interviews with a PSW and other staff. [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 related to the safe transferring of residents by staff, to be implemented voluntarily.

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Issued on this 1st day of September, 2021

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

Original report signed by the inspector.