Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

Rapport d'inspection prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de 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
Jul 24, 2019	2019_263524_0025	010735-19	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 on Mary Bucke
4 Mary Bucke Street ST. THOMAS ON N5R 5J6

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

INA REYNOLDS (524)

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 22, 2019.

During the course of the inspection, the inspector(s) spoke with the Executive Director, a Personal Support Worker and residents.

The inspector(s) also observed resident care provisions, resident and staff interactions, reviewed a resident's clinical records including assessments and care planning interventions, the home's investigation notes and policies and procedures related to this inspection.

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

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 staff used safe transferring and positioning techniques when assisting resident #001.

This inspection was initiated as a result of a Critical Incident (CIS) report submitted to the Ministry of Health and Long-Term Care on a specific date, related to unsafe transferring techniques that resulted in risk of harm to resident #001.

Review of the CIS and the home's investigation notes documented the following:
- on a specific date, a letter was issued to a Personal Support Worker (PSW) involved in the incident. The letter stated they had lifted resident #001 without another person and, as a result, there was an accident. The PSW had proceeded to put the resident to bed without ensuring they were not harmed during the incident or were at any possible risk. In addition, the PSW had failed to report the incident to the Registered Charge Nurse at the time it had occurred.

Review of resident #001's Resident Assessment Protocol (RAP) quarterly review assessment for a specific date and the care plan in Point Click Care (PCC) documented that resident #001 required total staff performance with the use of a lift for transfers. This was verified by PSW #102 in an interview.

Review of the home's policy "Use of Total Lift (A.K.A Hoyer Lift)" with reviewed date May 2018, stated that "two staff must be present when using a mechanical lift on any resident" and that the procedure requires "two (2) caregivers, one on either side of the bed."

In an interview, Executive Director (ED) #101 acknowledged that a Personal Support Worker had transferred resident #001 to bed alone and had provided improper care when they had not transferred the resident using safe transferring techniques.

The licensee has failed to ensure that staff used safe transferring and positioning techniques when assisting resident #001. [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 30th day of July, 2019

[redacted]

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

Original report signed by the inspector.