Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

Hamilton District
119 King Street West, 11th Floor
Hamilton, ON, L8P 4Y7
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Original Public Report

Report Issue Date: March 13, 2024	
Inspection Number: 2024-1217-0001	
Inspection Type: Critical Incident	
Licensee: Clarion Nursing Homes Limited	
Long Term Care Home and City: Clarion Nursing Home, Stoney Creek	
Lead Inspector Brittany Wood (000763)	**Inspector Digital Signature** Brittany Wood Digitally signed by Brittany Wood Date: 2024.03.19 11:15:20 -04'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s):
February 15-16, 2024, February 20-23, 2024

The following intake(s) were inspected:

- Intake: #00101234/Critical Incident (CI) #2721-000010-23 related to an injury.
- Intake: #00103441/CI #2721-000011-23 - Outbreak
- Intake: #00103784/CI #2721-000012-23 – Outbreak

The following **Inspection Protocols** were used during this inspection:

Resident Care and Support Services
Infection Prevention and Control

INSPECTION RESULTS

WRITTEN NOTIFICATION: Transferring and positioning techniques

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 40

Transferring and positioning techniques

s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

The licensee failed to ensure that staff use safe transferring devices or techniques when assisting residents.

Rationale and Summary

A Personal Support Worker (PSW) transferred a resident from the bed to bring them to the bathroom using a specialized device. The device is required to have a resident strapped on using both straps on each side. The PSW did not use both straps from the specialized device to the resident and the resident fell on the floor while being transferred from the bed to the bathroom that resulted in an laceration to the head. The PSW transferred the resident alone and with no support from another staff. According to the home's policy titled "Lifts and Transfers of residents" reviewed January 2023, stated that all lifts to transfer residents are to be accompanied by two PSW's.

The Director of Care (DOC) confirmed that PSW transferred the resident unsafely and did not follow the home's policy.

Failure to transfer the resident safely led to actual harm to the resident's safety.

Sources: CI Report #2721-000010-23, LTCH's policy titled "Lifts and Transfers of residents" reviewed January 2023 and interview with DOC. **[000763]**