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 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 Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Mar 18, 2013	2013_201167_0008	H-000962-12	Critical Incident System

Licensee/Titulaire de permis

CLARION NURSING HOMES LIMITED
337 HIGHWAY #8, STONEY CREEK, ON, L8G-1E7

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

CLARION NURSING HOME
337 HIGHWAY #8, STONEY CREEK, ON, L8G-1E7

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

MARILYN TONE (167)

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): March 13, 2013

During the course of the inspection, the inspector(s) spoke with the Director of Care and the Assistant Director of Care

During the course of the inspection, the inspector(s) Conducted a review of the health record for the identified resident, reviewed the home's investigation notes into the incident and reviewed relevant policies and procedures.

The following Inspection Protocols were used during this inspection:

Critical Incident Response

Falls Prevention

Findings of Non-Compliance were found during this inspection.

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 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 did not ensure that a staff member used safe transferring technique when assisting resident # 001.
a) The plan of care for resident # 001 directs staff to use the "Sarah Lift" and two staff assist when transferring them.
b) The home's policy related to use of mechanical lift indicates that two staff are required when transferring with the lift.
c) The home's Director of Care confirmed that staff are to use two staff when transferring with a mechanical lift.
d) On an identified date, it was confirmed that a staff member transferred resident # 001 using a mechanical lift without the assistance of a second staff member. [s. 36.]

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition. O. Reg. 79/10, s. 107 (3).
2. An environmental hazard, including a breakdown or failure of the security system or a breakdown of major equipment or a system in the home that affects the provision of care or the safety, security or well-being of residents for a period greater than six hours. O. Reg. 79/10, s. 107 (3).
3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).
5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee did not ensure that the Director was notified within one business day after resident # 001 sustained an injury that resulted in a transfer to hospital.
a) Resident # 001 was noted by staff to have an injury on a specified date.
b) The resident was transferred to hospital on for an x-ray and assessment on the same day.
c) The critical incident report was submitted to the Director three days later.
The Director was not notified until three days after the injury and transfer to hospital occurred. [s. 107. (3)]

Issued on this 18th day of March, 2013

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