Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection 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 sions de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Apr 15, 2016	2016_384161_0014	010140-16 X 000062-16	Critical Incident System

Licensee/Titulaire de permis

Omni Health Care Limited Partnership on behalf of 0760444 B.C. Ltd. as General Partner

2020 Fisher Drive Suite 1 PETERBOROUGH ON K9J 6X6

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

GARDEN TERRACE
100 Aird Place KANATA ON K2L 4H8

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

KATHLEEN SMID (161)

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): on site April 13, 14, 2016.

During the course of the inspection, the inspector(s) observed identified residents, reviewed their health care records and reviewed salient policies and procedures.

During the course of the inspection, the inspector(s) spoke with the identified residents, Personal Support Workers (PSW), a Registered Practical Nurse, RAI Coordinator, Director of Care and the Administrator.

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

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	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 :

On an identified date in December 2015 the licensee failed to ensure that a PSW used a safe transferring technique when he transferred resident #002 from a chair to bed with a mechanical lift, by himself.

On an identified dated in December 2015, PSW #101 asked PSW #102 to assist with the transfer of resident #002 to bed with the use of a mechanical lift. PSW #102 was busy performing care to another resident and was unable to assist PSW #101 immediately. PSW #101 proceeded to transfer resident #002 with a mechanical lift without the assistance of another staff member. PSW #102 observed PSW #101 leave the room of resident #002 alone, with a mechanical lift. PSW #102 asked PSW #101 why he didn't wait for her to assist in transferring resident #002. PSW #101 did not respond to her question. The following day, PSW #102 informed her supervisor of the events from the evening before.

On an identified date in December 2015 the home's Assistant Director of Care called the MOHLTC Emergency pager to report that PSW #101 had transferred resident #002 with a mechanical lift without the assistance of a second staff member. This was followed by a submission of a Critical Incident Report to the Director.

On April 13, 2016, Inspector #161 reviewed the health care records of resident #002. It was noted in the care plan dated October 2015 that resident #002 was to be transferred with a mechanical lift with the assistance of two persons.

On April 13, 2016 the Inspector asked for and received from the home's Administrator, the home's policy titled "Safety – Mandatory Lift and Transfer Procedures – CS-6.2" dated January 2011. A review of this policy indicated that to ensure the safety of residents, two staff members shall be present during a mechanical lift transfer.

On April 13, 2016 during discussion with PSW #101, he indicated to Inspector #161 that he had transferred resident #002 by himself using a mechanical lift. PSW #101 further indicated that he knew he should have transferred resident #002 with another staff member to ensure the safety of the resident. PSW #101 indicated to Inspector #161 that it was a lapse in his judgement.

On April 13, 2016, during discussion with the home's Administrator and Director of Care, they indicated to Inspector #161 that PSW #101 was disciplined for his action. [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 all staff use safe transferring techniques when operating a mechanical lift and that all staff must follow the home's policies and procedures related to mechanical lifts, to be implemented voluntarily.

Issued on this 15th day of April, 2016

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

Original report signed by the inspector.