Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

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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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Aug 16, 17, 18, Sep 2, 2011	2011_099188_0012	Critical Incident

Licensee/Titulaire de permis

CORPORATION OF THE CITY OF TIMMINS
481 Melrose Blvd., TIMMINS, ON, P4N-5H3

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

GOLDEN MANOR
481 MELROSE BOULEVARD, TIMMINS, ON, P4N-5H3

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

MELISSA CHISHOLM (188)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Nursing Care Coordinator, the Informatics Coordinator, Registered nursing staff, Personal Support Workers (PSW) and residents.

During the course of the inspection, the inspector(s) conducted a walk through of resident care areas, observed residents named in the critical incidents, reviewed health care records of residents named in the critical incidents and reviewed various policies and procedures.

The following Inspection Protocols were used in part or in whole during this inspection:

Continence Care and Bowel Management

Critical Incident Response

Falls Prevention

Hospitalization and Death

Personal Support Services

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

Definitions	Définitions
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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. 107. Reports re critical incidents

Specifically failed to comply with the following subsections:

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.
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.
3. A missing or unaccounted for controlled substance.
4. An injury in respect of which a person is taken to hospital.
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 sayants :

1. Inspector reviewed four critical incident reports. The injuries that resulted in transfer to hospital were reported to the Director outside of the one business day reporting time frame. The licensee failed to ensure the Director is notified within one business day of any injury that results in a transfer to hospital. [O.Reg. 79/10, s.107(3)]

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 141. Licensee to stay in contact

Specifically failed to comply with the following subsections:

s. 141. (1) Every licensee of a long-term care home shall maintain contact with a resident who is on a medical absence or psychiatric absence or with the resident's health care provider in order to determine when the resident will be returning to the home. O. Reg. 79/10, s. 141 (1).

Findings/Faits sayants :

1. Inspector reviewed the health care record, including progress notes for two residents following hospitalizations. The progress notes for both these residents contain no documentation that indicates contact was made to determine the return date to the home. The licensee failed to maintain contact with a resident who is on a medical leave, or the health care provider, to determine the return date to the home.[O.Reg. 79/10, s.141(1)]
2. Inspector spoke with a Registered Practical Nurse (RPN) who identified to the inspector that typically the home does not contact the hospital and that the home typically awaits the hospital to contact them on the date of expected return. The licensee failed to maintain contact with a resident who is on a medical leave, or the health care provider, to determine the return date to the home. [O.Reg. 79/10, s.141(1)]

WN #3: 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 sayants :

1. Inspector reviewed a critical incident. Through the investigation conducted by the licensee, it was determined that the staff members present during the lift/transfer did not follow the home's policy related to lifts and transfers. The home's policy identifies two staff are required for lifts/transfers, one to guide and monitor the resident and the second staff member to operate the lift. The investigation concluded this was not followed. The licensee failed to ensure safe transferring techniques were used when assisting residents. [O.Reg. 79/10, 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 ensuring all staff use safe transferring techniques when assisting residents, to be implemented voluntarily.

Issued on this 9th day of September, 2011

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