Ontario

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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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
Oct 9, 2013	2013_184124_0022	O-000403-13, O-000409-13	Critical Incident System

Licensee/Titulaire de permis

OMNI HEALTH CARE LIMITED PARTNERSHIP
1840 LANSDOWNE STREET WEST, UNIT 12, PETERBOROUGH, ON, K9K-2M9

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

MAPLEWOOD
12 MAPLEWOOD AVENUE, BOX 249, BRIGHTON, ON, K0K-1H0

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

LYNDA HAMILTON (124)

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): September 30, October 1, 2, 8, 2013.

This inspection included logs O-00406-13(CI 2717-000002-13), O-000409-13(CI 2717-000004-13), O-000581-13(CI 2717-000011-13) and O-000844-13(CI 2717-000019-13) related to the specified critical incidents.

During the course of the inspection, the inspector(s) spoke with Residents, Administrator/Director of Care, Clinical Care Co-ordinator, Registered Nurses, Registered Practical Nurses and Personal Support Workers.

During the course of the inspection, the inspector(s) completed walking tours of the home, observed staff-resident interactions, made general observations regarding resident care, reviewed resident health records and the home's policy, "SARA/SARA 2000/SARA 3000 LIFT, CS-6.15".

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

Prevention of Abuse, Neglect and Retaliation

Responsive Behaviours

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 failed to comply with O.Reg 79/10 s. 36 whereby staff did not use safe transferring and positioning techniques when assisting Resident#6.

Resident#6's plan of care in place at the time of the incident described Resident#6 as requiring extensive assistance and a sit to stand mechanical lift for all transfers.

Resident#6's progress notes, of a specific date stated that the resident was being transferred to bed by Sara Lift and the resident's hand got caught between the Sara lift and the bedrail.

Personal Support Workers(PSW) #S106 and #S107 reported that during the transfer, they positioned Resident#6 toward the top of the bed and when lowering Resident#6 to the bed the resident's hand was pinched between the Sara lift and the bed rail. At this time, no swelling or bruising was noted. PSWs #S106 and #S107 stated later they checked Resident#6's hand and the hand was swollen.

The progress notes of the next day describe Resident#6's hand as being very bruised and swollen.

Six days after the incident, Resident#6's physician assessed the resident's hand and ordered an x-ray and ice pack treatments. There is documentation in Resident#6's progress notes up to ten days after the incident that described Resident#6's hand as bruised and the resident requiring Tylenol for hand discomfort.

Resident#6 was not transferred safely and sustained an injury during the transfer. [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 techniques when assisting residents, particularly those residents with half bed rails, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee failed to comply with the LTCHA, 2007, s.24.(1)2 whereby the suspicion of abuse of a resident by anyone was not immediately reported to the Director.

Registered Nurse(RN) #S102 reported that on a specific date, Resident#6 described being touched by Resident#5 in a way that was non-consensual and of a sexual nature.

RN #S102 contacted the Administrator to advise her of the incident. Both RN #S102 and the Administrator reported to the inspector that they had not contacted the Ministry of Health and Long Term Care at the time of the incident.

Six days later, Critical Incident Report 2717-000011-13 was submitted describing this incident of resident to resident abuse. [s. 24. (1)]

Issued on this 9th day of October, 2013

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