Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

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

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Sep 11, 2020	2020_640601_0017	002017-20, 007801-20, 010599-20, 014794-20	Critical Incident System

Licensee/Titulaire de permis

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

2020 Fisher Drive Suite 1 PETERBOROUGH ON K9J 6X6

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

KARYN WOOD (601)

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 1, 2, and 3, 2020.

The following intakes were completed in this Critical Incident System Report (CIS) Inspection:

Two logs related to a fall that resulted in a significant change in condition.

A log related to allegations of staff to resident abuse.

A log related to an improper transfer of a resident.

During the course of the inspection, the inspector(s) spoke with The Administrator, Clinical Care Coordinator (CCC)/RAI Coordinator, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), and residents.

The inspector also reviewed resident health care records, internal investigation documentation, observed the delivery of resident care and services, including staff to resident interactions.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control
Personal Support Services
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **0 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	Légende 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 has failed to ensure that PSW #102 used safe transferring techniques when assisting resident #001 with a transfer.

Inspector #601 reviewed a Critical Incident System Report (CIS) that was submitted to the Director for an incident involving resident #001 and PSW #102. On a specified date, PSW #102 was transferring resident #001, the resident had a specified change in condition and the resident was lowered to the floor.

A review of the licensee's procedures for their "Lifting" policy" directed that a lifting code diagram specifying the type of lift or transfer is placed on the head board of each resident's bed. Each code indicates the resident's name to further ensure the proper mechanical device is followed for that resident and shall be adhered to without exception.

A review of resident #001's written care plan by Inspector #601 identified that on a specified date, RPN #105 had changed resident #001's care plan from one-person physical assistance for transfers to two-person physical assistance.

A review of resident #001's progress notes by Inspector #601 identified the following:

-RPN #105 and RN #101 documented on a specified date that resident #001 was changed from a one-person transfer to a two person transfer for a specified reason.

-RN #103 documented on a specified date that PSW #102 was transferring resident #001, the resident had a specified change in condition and the resident was lowered to the floor.

During an interview, PSW #102 indicated to Inspector #601 that on the specified date they had transferred resident #001 on their own and the resident had a specified change in condition and the resident was lowered to the floor. PSW #102 further indicated that resident #001's transfer logo had been changed from one-person to a two-person for a specified reason. PSW #102 acknowledged they knew that resident #001 required two-people for transfers and they should have gone to get assistance before transferring the resident.

During separate interviews, the Administrator and RN #103 indicated to Inspector #601 that resident #001 had been changed from one-person to a two-person transfer for a specified reason. According to the Administrator, on a specified date and time, PSW #102 had not used safe transferring when they did not follow the resident's two-person transfer logo.

The licensee failed to ensure that PSW #102 used safe transferring techniques on the specified date and time. [s. 36.]

Issued on this 14th day of September, 2020

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

Original report signed by the inspector.