

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007 Soins de longue durée Rapport d'inspection

Ministère de la Santé et des

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 Direction de l'amélioration de la performance et de la conformité

Ottawa Service Area Office 347 Preston St, 4th Floor OTTAWA, ON, K1S-3J4 Telephone: (613) 569-5602 Facsimile: (613) 569-9670 Bureau régional de services d'Ottawa 347, rue Preston, 4iém étage OTTAWA, ON, K1S-3J4 Téléphone: (613) 569-5602 Télécopieur: (613) 569-9670

## Public Copy/Copie du public

Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Dec 1, 2, 6, 2011	2011_044161_0033	Critical Incident
Licensee/Titulaire de permis		
CITY OF OTTAWA  Long Term Care Branch, 275 Perrier A  Long-Term Care Home/Foyer de so		
PETER D. CLARK CENTRE	K2G-6P8	

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 inspection.

During the course of the inspection, the inspector(s) spoke with a Charge Nurse on an identified unit.

During the course of the inspection, the inspector(s) reviewed the health care record of an identified resident.

The following Inspection Protocols were used during this inspection:

**Personal Support Services** 

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES		
Legend	Legendé	
WN – Written Notification	WN – Avis écrit	
VPC - Voluntary Plan of Correction	VPC – Plan de redressement volontaire	
DR - Director Referral	DR – Aiguillage au directeur	
CO - Compliance Order	CO – Ordre de conformité	
WAO - Work and Activity Order	WAO – Ordres : travaux et activités	



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 prévue le Loi de 2007 les fovers de soins de longue

Non-compliance with requirements under the Long-Term Care 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 Homes Act, 2007 (LTCHA) was found. (A requirement under the soins de longue durée (LFSLD) a été constaté. (Une exigence de la LTCHA includes the requirements contained in the items listed in 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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care Specifically failed to comply with the following subsections:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

## Findings/Faits saillants:

- 1. The licensee failed to comply with s. 6(7) of the Long Term Care Home Act, 2007, in that an identified resident was not transferred as per care set out in her care plan.
- 2. In November 2011, an identified resident was transferred from the toilet to her wheelchair by one PSW using a mechanical lift.
- 3. The identified resident's plan of care indicates transferring using a mechanical lift with the assistance of 2 staff.

WN #2: 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 s. 36 of the Long Term Care Home Act, 2007, in that an identified resident was not transferred safely with a mechanical lift.
- 2. In November 2011, an identified resident was being transferred from the toilet to her wheelchair by one PSW using a mechanical lift.
- The resident slipped from the sling, landed on the floor and sustained a hematoma to her left lower leg.

Issued on this 6th day of December, 2011



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 prévue le Loi de 2007 les foyers de soins de longue

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

Kathleen Smid