Ministry of Health and Long-Term Care

Ministére de la Santé et des Soins de longue durée

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

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

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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
Sep 5, 6, 7, 12, 13, 18, 2012	2012_030150_0024	Critical Incident

Licensee/Titulaire de permis

TOWNSHIP OF OSGOODE CARE CENTRE
7650 SNAKE ISLAND ROAD, METCALFE, ON, K0A-2P0

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

TOWNSHIP OF OSGOODE CARE CENTRE
7650 SNAKE ISLAND ROAD, METCALFE, ON, K0A-2P0

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

CAROLE BARIL (150)

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, Director of Care, Registered Nurse, Registered Practical Nurse, Personal Support Worker, Physiotherapy Aid and residents.

During the course of the inspection, the inspector(s) reviewed the health records of several residents, reviewed the home's policy/procedures for "Lift" revision date of October 2010, observed residents' activities.

During the course of this inspection the inspector conducted four critical incident inspections, log #O-002893-11, #O-000245-12, #O-000777-12, #O-000861-12.

The following Inspection Protocols were used during this inspection:

Pain

Personal Support Services

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

Legend	Legendé
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 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 has failed to comply with LTCHA 2007, S.O. 2007, s. 6 (7), in that the care set out in the plan of care was not provided to the residents as specified in the plan.

In March 2012, resident #1 had a bath. While in the tub room in the presence of a staff, the resident fell. The resident was holding onto a bar with the wheelchair behind her/him when the resident lost her/his balance and fell. This injury required the resident to be transferred to the hospital.

The hospital report indicates a leg internal rotation with fracture.

The resident's plan of care indicates that the resident had past hip fracture with interventions for transferring of staff x1 provide weight bearing support to transfer by helping the resident to sit and to stand up to transfer and for bathing one person to provide extensive physical assistance with bathing and to assist with transfer.

On September 7, 2012, the physiotherapy aid states that the resident was a 1 person assist for walking and unable to follow directions consistently and needed to be directed with ongoing assistance for transfers and walking. (log#O-000777-12)
2. In December 2011, resident #3 was transferred by a staff to bed using a mechanical lift and the resident sustained an injury causing skin tear/laceration to a leg requiring a transfer to hospital.

The resident's plan of care indicates the following interventions for transferring where identified. Listed two staff to transfer with mechanical lift for all transfers. The resident is unable to participate and is totally dependent for the entire process.

The administrator and director of care confirmed that resident #3 care plan was not followed in that the resident was transferred by 1 staff member and not 2 staff members. (log#O-002893-11)

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 care set out in the plan of care are provided to the resident as specified in the plan., to be implemented voluntarily.

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 has failed to comply with O. Reg 79/10, s. 36 in that the that staff did not use safe transferring techniques when assisting resident in wheelchair.

In January 2012, resident #2 was being wheeled into the dining room by wheelchair and the resident's foot became stuck on the floor and got caught under the wheelchair.

A mobile x-ray taken showed fractures and the resident required to be transferred to the hospital.

September 7, 2012, the physiotherapist aid states that often the foot rests are removed from the wheelchairs to promote residents to self propel. When assisting self propelling residents with their wheelchair mobility, the staff is to turn the wheelchair with the resident backyard and pull the wheelchair towards the destination to prevent the feet to get under the wheelchair.

The administrator and the director of care have made the staff aware of the risk of injury and instructed them of the safety precaution when assisting residents who self proper in wheelchair. (log#O-000245-12)

Issued on this 18th day of September, 2012

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